Supreme Court, U.S.
FILED
031609 MAY 28 2004
OFFICE OF THE CLERK

No. 03-

In the Supreme Court of the United States

PROVIDENCE HEALTH SYSTEM-WASHINGTON,
d/b/a Providence Yakima Medical Center,
d/b/a Providence Yakima Medical Center
Skilled Nursing Facility,

Petitioner,

v.

TOMMY G. THOMPSON, Secretary, Department
of Health and Human Services,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

MICHAEL MADDEN
Counsel of Record
BENNETT BIGELOW & LEEDOM, P.S.
1700 SEVENTH AVENUE
SUITE 1900
SEATTLE, WA 98101-1355
(206) 622-5511

Counsel for Petitioner

Becker Gallagher Legal Publishing, Inc.
800.890.5001

QUESTION PRESENTED FOR REVIEW

Whether the skilled nursing facility established by the Petitioner is a "new provider" under 42 C.F.R. § 413.30(e), thus qualifying for an exemption from the "routine cost limits" under the Medicare program?

PARTIES TO THE PROCEEDINGS BELOW

1. Petitioner Providence Health System-Washington, d/b/a Providence Yakima Medical Center, d/b/a Providence Yakima Medical Center Skilled Nursing Facility.

2. Respondent Tommy G. Thompson, Secretary, Department of Health and Human Services.

CORPORATE DISCLOSURE STATEMENT

Providence Health System-Washington is a non-profit corporation. Providence Yakima Medical Center d/b/a Providence Yakima Medical Center Skilled Nursing Facility is an operating unit of Providence Health System-Washington.

TABLE OF CONTENTS

Question Presented for Review i

Parties to the Proceedings Below ii

Corporate Disclosure Statement ii

Table of Contents iii

Table of Authorities vi

Opinions Below 1

Jurisdiction 1

Statement of the Case 1

Reasons for Granting the Petition 4

I. Certiorari Should Be Granted In Order To Resolve A Direct Conflict Among Decisions Of The Circuit Courts of Appeals 4

A. The Fourth Circuit And The Sixth Circuit Have Adopted A Plain Meaning Interpretation Of The Word "Provider." 5

B. Three Other Circuit Courts Of Appeals Have Adopted A Method Of Analysis Which Conflicts With That Of The Fourth Circuit And The Sixth Circuit 12

C. Certiorari Should Be Granted In Order To Permit This Court To Resolve The Direct Conflict Between The Circuit Courts Of Appeals 13

II. Review Is Warranted To Settle The Important Question Of Whether, In Light Of The Court's Holding In United States v. Mead, An Agency's Interpretation Of Its Own Regulation Is To Be Accorded Mandatory Judicial Deference 13

Conclusion 20

Appendix

Appendix A
Order of the Ninth Circuit Court of Appeals Denying Petition for Rehearing,
Dated March 1, 2004 . . . . . 1a

Appendix B
Judgment of the Ninth Circuit Court of Appeals,
Dated December 17, 2003 . . . . . 3a

Appendix C
Opinion of the Ninth Circuit Court of Appeals,
Dated December 17, 2003 . . . . . 5a

Appendix D
Order of the United States District Court for the Eastern District of Washington Denying Defendant's Motion for Summary Judgment,
Dated July 25, 2002 . . . . . 18a

Appendix E
Provider Reimbursement Review Board Hearing Decision,
Dated May 21, 2001 . . . . . 33a

TABLE OF AUTHORITIES

Cases

Ashtabula County Medical Center v.Thompson, 191 F. Supp. 2d 884 (N.D. Ohio 2002) 9

Ashtabula County Medical Center v. Thompson, 352 F.3d 1090 (6th Cir. 2003) 10, 11, 12

Bethesda Hosp. Ass'n v. Bowen, 485 U.S. 399, 108 S. Ct. 1255, 99 L. Ed. 2d 460 (1988) 18, 19

Bowles v. Seminole Rock & Sand Co., 325 U.S. 410, 65 S. Ct. 1215, 89 L. Ed. 1700 (1945) 14, 16, 17, 19

Chevron U.S.A. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984) . . . . . *passim*

Christensen v. Harris County, 529 U.S. 576, 120 S. Ct. 1655, 146 L. Ed. 2d 621 (2000) 14, 15, 16, 17, 19

Ford Motor Credit Co. v. Milhollin, 444 U.S. 555, 100 S. Ct. 790, 63 L. Ed. 2d 22 (1980) 14

Gardebring v. Jenkins, 485 U.S. 415, 99 L. Ed. 2d 515, 108 S. Ct. 1306 9

Lyng v. Payne, 476 U.S. 926, 106 S. Ct. 2333, 90 L. Ed. 2d 921 (1986) 14

Martin v. Occupational Safety & Health Rev. Comm'n, 499 U.S. 144, 150-151 (1991) 8, 14, 18, 19

Maryland General Hospital v. Thompson, 308 F.3d 340 (4th Cir. 2002) . . . . . *passim*

Paragon Health Network v. Thompson, 251 F.3d 1141 (7th Cir. 2001) 12, 13

Providence Health System-Washington v. Thompson, 353 F.3d 661 (9th Cir. 2003) 3, 12, 17, 19

Skidmore v. Swift & Co., 323 U.S. 134, 65 S. Ct. 161, 89 L. Ed. 124 (1944) 14, 15, 17, 19

South Shore Hospital, Inc. v. Thompson, 308 F.3d 91 (1st Cir. 2002) 12, 13, 18, 19

Thomas Jefferson Univ. v. Shalala, 512 U.S. 504, 114 S. Ct. 2381, 129 L. Ed. 2d 405 (1994) 13, 16, 17

Udall v. Tallman, 380 U.S. 1, 85 S. Ct. 792, 13 L. Ed. 2d 616 (1965) 14

United States v. Mead Corp., 533 U.S. 218, 121 S. Ct. 2164, 150 L. Ed. 2d 292 (2001) . . . . . *passim*

Statutes

5 U.S.C. § 706(2)(a) 10

28 U.S.C. § 1254(1) 1

42 U.S.C. § 1395oo(a) 18

42 U.S.C. § 1395oo(f)(1) 4, 18

42 U.S.C. § 1395x(u) 6, 11

42 U.S.C. § 1395x(v)(1)(A) 18

Regulations

42 C.F.R. § 413.30 2

42 C.F.R. § 413.30(a) 2

42 C.F.R. § 413.30(e) . . . . . *passim*

42 C.F.R. § 1395i-3(a) 11

42 C.F.R. § 1395x(u) 11

Other

Merrill & Hickman, Chevron's Domain, 89 Geo. L. J. 833 (2001) 16

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit is reported at 353 F.3d 661 (9th Cir. 2003). Appendix C. The order of the Ninth Circuit denying the Petition for Rehearing En Banc in such case is unreported. Appendix A.

The opinion of the United States District Court for the Eastern District of Washington is not officially reported. See Providence Health System-Washington v. Thompson, D.C. No. CV-01-03060-RHW (E.D. Wash. July 25, 2002). Appendix D.

JURISDICTION

The Judgment of the United States Court of Appeals for the Ninth Circuit was entered on December 17, 2003. Appendix B. A timely Petition for Rehearing En Banc was denied on March 1, 2004. Appendix A. The jurisdiction of the Supreme Court is invoked under 28 U.S.C. § 1254(1).

STATEMENT OF THE CASE

The Medicare Program provides reimbursement for inpatient services delivered in a skilled nursing facility ("SNF").[1] During the time periods pertinent to this action, the Medicare Program paid for the "reasonable costs" of inpatient

[1] The Secretary of the Department of Health and Human Services ("DHHS") is responsible for the administration of the Medicare Program. The Centers for Medicare & Medicaid Services ("CMS") is the component of the DHHS charged with the administration of the Medicare Program. During the time periods pertinent to this action, CMS was known as the Health Care Financing Administration, or "HCFA". Accordingly, the acronym "HCFA" will be used in this Petition.

services provided in a SNF. Payment was made on a per patient, per diem basis. Payment for such costs was subject to a "routine cost limit" ("RCL"), which placed a ceiling on the amount of the per diem payment. 42 C.F.R. § 413.30(a). However, a SNF was entitled to an exemption from the RCL if it qualified as a "new provider":

> Exemptions from the [routine cost] limits imposed under this section may be granted to a new provider. A new provider is a provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years. An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient.

42 C.F.R. § 413.30(e) (emphasis added).[2] In order to obtain an exemption from the RCL, a provider was required to submit a new provider exemption request to its Medicare fiscal intermediary. 42 C.F.R. § 413.30(e).[3] The fiscal intermediary was required to make a recommendation on the request to HCFA, which then issued a final decision. Id.

---

[2] Effective September 7, 1999, 42 C.F.R. § 413.30 was revised. The new provider exemption was moved from subsection (e) to subsection (d) of the regulation. Final Rule, 64 Fed. Reg. 42610 (Aug. 5, 1999). All references in this Petition are to the prior codification.

[3] Providence Yakima's fiscal intermediary is Premera Blue Cross. During the time periods pertinent to this action, Premera Blue Cross was known as Blue Cross of Washington and Alaska. Accordingly, the terms "Blue Cross" or "the Intermediary" will be used in this Petition.

Providence Health System-Washington, d/b/a Providence Yakima Medical Center, d/b/a Providence Yakima Medical Center Skilled Nursing Facility ("Providence Yakima") opened its SNF in May of 1993. Providence Yakima requested the Intermediary and HCFA to issue a SNF new provider exemption for the fiscal year ending ("FYE") 12/31/93 through FYE 12/31/96 in accordance with 42 C.F.R. § 413.30(e). HCFA denied the exemption request. HCFA based its denial on the premise that Providence Yakima's SNF "was established due to the purchase and relocation of 12 beds from Summitview Manor." Summitview Manor ("Summitview") is an independent, separately-licensed skilled nursing facility located in Yakima. HCFA asserted that Providence Yakima's purported "purchase and relocation of 12 beds" from Summitview constituted a "relocation" of Summitview to Providence Yakima.

The record establishes that HCFA's reference to the "purchase and relocation of 12 beds" from Summitview to Providence Yakima is not accurate. The transfer between Summitview and Providence Yakima involved certificate of need ("CON") bed allocation rights under Washington CON law. *See*, Providence Health System-Washington v. Thompson ("Providence"), 353 F.3d 661, 663 (9th Cir. 2003). The Ninth Circuit recognized that the "transfer of bed rights allowed Providence [Yakima] to obtain a CON, and is the only connection between Providence [Yakima] and Summitview." Id. (emphasis added). The undisputed record establishes that (1) there is no physical continuity between Providence Yakima's SNF and Summitview, (2) there is not, and there has never been, any legal or operational relationship between Providence Yakima and Summitview, (3) there was no transfer or assignment of Summitview's nursing home license to Providence Yakima, (4) there was no transfer of personnel, equipment, or supplies from Summitview to Providence

Yakima, and (5) there was no transfer of patients from Summitview to Providence Yakima. Again, the transfer of the CON bed allocation rights is "the only connection" between Summitview and Providence Yakima.

Providence Yakima thereafter filed a Request for Hearing with the Provider Reimbursement Review Board ("PRRB") appealing HCFA's denial of its request for a new provider exemption. A hearing was held before the PRRB. The PRRB issued a decision affirming HCFA's denial of the exemption. The PRRB decision constitutes the final decision of the Secretary and is therefore subject to judicial review. 42 U.S.C. § 1395oo(f)(1).

REASONS FOR GRANTING THE PETITION

I. Certiorari Should Be Granted In Order To Resolve A Direct Conflict Among Decisions Of The United States Circuit Courts Of Appeals.

As noted above, the sole issue in this case is whether the SNF established by Providence Yakima is a "new provider" under 42 C.F.R. § 413.30(e), thus qualifying for an exemption from the Medicare "routine cost limits." In addition to the Opinion issued by the Ninth Circuit Court of Appeals in this case, the same issue has been addressed by four other Courts of Appeals. Two of the Courts (the Fourth Circuit and the Sixth Circuit) have resolved the issue in favor of parties who are in the same position as Providence Yakima. (The Sixth Circuit's opinion was issued just two days after the issuance of the Opinion in this case.) The other Courts (the First Circuit and the Seventh Circuit) have resolved the issue in favor of the Secretary. As discussed below, Providence Yakima believes that the Fourth Circuit and the Sixth Circuit, by focusing on the plain meaning of the crucial word "provider," have arrived at

a result which straightforwardly resolves the issue in a manner that does not add unnecessary semantic complexity to an already complex regulatory scheme.

A. The Fourth Circuit And The Sixth Circuit Have Adopted A Plain Meaning Interpretation Of The Word "Provider."

The resolution of the issue in this case depends upon whether the word "provider" in 42 C.F.R. § 413.30(e) is determined to be ambiguous or not ambiguous. Based upon the principle that a word in a regulation should be given its plain or ordinary meaning, the Fourth Circuit and the Sixth Circuit have concluded that the word "provider" is not ambiguous. Thus, they have held that a "provider" is a physical facility or an institution, not an ambiguous and inchoate amalgamation of tangible and intangible characteristics.

The Fourth Circuit Court of Appeals adopted the plain meaning approach in Maryland General Hospital v. Thompson, 308 F.3d 340 (4th Cir. 2002) ("Maryland General"). The facts in Maryland General mirror the facts in this case: (1) Maryland General Hospital ("MGH") purchased "the right to operate 24 [nursing home] beds" from three existing nursing homes in order to establish a new hospital-based SNF; (2) MGH purchased the nursing home bed rights due to the requirements of Maryland's certificate of need law; (3) the nursing homes from which MGH purchased the bed rights "were not connected or related to MGH in any way"; (4) MGH applied for a new provider exemption; and (5) the Secretary denied MGH's request. Maryland General, 308 F.2d at 342-343.

The Fourth Circuit reversed the Secretary's denial of MGH's request for a new provider exemption. The court held:

Section 413.30(e) does not define "provider," but the structure and wording of the regulation suggest that the provider is the business entity or institution providing the skilled nursing services. This reading is consistent with the meaning attached to a similar term in another part of the Medicare Act. *See* 42 U.S.C.A. § 1395x(u) (defining "provider of services" as "a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, [or] hospice program"). This business-entity-specific reading of the regulation is also supported by the explanation of the "new provider" exemption contained in the version of Medicare's "Provider Reimbursement Manual" ("PRM") in effect at the time MGH purchased the beds:

> A new provider is an *institution* that has operated in the manner for which it is certified in the program (or the equivalent thereof) under present and previous ownership for less than 3 full years. For example, an *institution* that has been furnishing only custodial care to patients for 2 full years prior to its becoming certified as a hospital furnishing covered services to Medicare beneficiaries, shall be considered a "new provider" for 3 full years from the effective date of certification. However, if an *institution* had been furnishing hospital health care services for 2 full years prior to its certification, it shall only be considered a "new provider" in its third full year of operation, which is its first full year of participation in the program.

> Although a complete change in the operation of the *institution*, as illustrated above, shall affect whether and how long a provider shall be considered a "new provider," changes of the *institution's* ownership or geographic location do not in [themselves] alter the type of health care furnished and shall not be considered in the determination of the length of operation.

PRM § 2604.1 (emphasis added). These repeated references to an "institution" indicate that application of the new provider exemption depends upon the ownership and operation of the business entity that is providing the skilled nursing services. There is no dispute that neither MGH nor any previous owner of MGH had provided inpatient skilled nursing services before the [MGH] Transitional Care Center was established. Thus, it would appear that MGH meets the requirements for a "new provider" as set forth in 42 C.F.R. § 413.30 (e).

Maryland General, 308 F.3d at 343-344 (emphasis in original).

In Maryland General, the Secretary made the same argument that he is making in this case: MGH was not a "new provider" because it purchased bed rights from "unrelated skilled nursing facilities that had been operating for more than three years." Maryland General, 308 F.2d at 344. The Secretary also argued that there had been "a change of ownership" of the beds. Maryland General, 308 F.2d at 344. The Fourth Circuit responded to the Secretary's argument as follows:

> We find this argument to be rather remarkable. Section 413.30(e) quite plainly focuses on the "newness" of the

> provider institution itself, a reading with which the Secretary purports to agree. *See* Brief of Appellee at 25 (stating that when determining whether the new provider exemption is applicable, the Secretary "looks at the operation of the *institution* under both past and present ownership as required by the regulation" (emphasis added)). When applying the exemption in this case, however, the Secretary has not focused on the "newness" of the institution providing the services, but has instead focused on the "newness" of one particular asset of that institution. Such an approach could be sustained only if Section 413.30(e) were ambiguous and the Secretary's interpretation reasonable. *See* Martin v. Occupational Safety & Health Rev. Comm'n, 499 U.S. 144, 150-51 (1991). ("In situations in which the meaning of regulatory language is not free from doubt, the reviewing court should give effect to the agency's interpretation so long as it is reasonable." (internal quotation marks and alteration omitted)).

Maryland General, 308 F.2d at 344-345 (emphasis in original).

The Maryland General court concluded as follows:

> Notwithstanding the absence of a definition of "provider," we simply cannot conclude that Section 413.30(e) is ambiguous. Given the ordinary meaning of the word "provider" and the manner in which it is used in the regulation, Section 413.30(e) can only be understood as focusing on the business institution that is providing the skilled nursing services. If that institution, whether under its current or prior ownership, has operated as a skilled nursing facility for more than three years, then it is not entitled to the new provider exemption. If that institution under current or prior

ownership has not previously operated as a skilled nursing facility, then it is entitled to the new provider exemption, even if the institution has purchased some of its assets from skilled nursing facilities that have operated for more than three years. See Ashtabula, 191 F. Supp. 2d at 893 (concluding that "the term provider refers to the institution applying for the exemption...not merely to its intangible characteristics or attributes" and holding that a newly created facility was entitled to the new provider exemption notwithstanding the institution's purchase of certificate of need rights from an unrelated SNF). Because MGH under any ownership had not previously operated a skilled nursing facility when it applied for the exemption, we conclude that MGH qualified as a "new provider" under Section 413.30(e).

In sum, we conclude that "provider" as used in Section 413.30(e) unambiguously refers to the business institution providing the skilled nursing services. It therefore follows that the regulation permits consideration of the institution's past and current ownership, but not the past and current ownership of a particular asset of that institution. The Secretary's interpretation, however, equates the ownership of an institution providing skilled nursing services with the ownership of a particular asset of that institution. Since there is no language in the regulation that would permit the denial of the exemption because an asset of the new institution was previously owned by an unrelated SNF, the Secretary's interpretation is inconsistent with the plain language of the regulation and cannot be allowed to stand. See Gardebring v. Jenkins, 485 U.S. 415, 430, 99 L. Ed. 2d 515, 108 S. Ct. 1306 (1988) (explaining that a reviewing court should be "hesitant to

> substitute an alternative reading for the Secretary's [reading of his own regulation] unless that alternative reading is compelled by the regulation's plain language"); see also 5 U.S.C.A. § 706 (2)(A) (requiring a reviewing court to "set aside agency action, findings, and conclusions" that are "not in accordance with law").
>
> ***
>
> In this case, the Secretary's interpretation is altogether untethered from the plain language of the regulation.

Maryland General, 308 F.3d 346-348 (emphasis added).

In an opinion issued on December 19, 2003 (two days after the issuance of the Ninth Circuit's Opinion in this case), the Sixth Circuit resolved the issue in the same manner as the Fourth Circuit. Ashtabula County Medical Center v. Thompson, 352 F.3d 1090 (6th Cir. 2003) ("Ashtabula"). The facts in Ashtabula are exactly parallel to the facts in this case: (1) Ashtabula County Medical Center ("ACMC") purchased "the right, title, and interest" to 15 nursing home beds that had been previously operated by the Ashtabula County Home ("ACH"); (2) ACMC purchased the nursing home bed rights from ACH due to the requirements of Ohio's certificate of need law; (3) there was no other connection between ACMC and ACH; (4) ACMC applied for a new provider exemption; and (5) the Secretary denied ACMC's request on the grounds that, due to the transfer of nursing home bed rights, a "change of ownership" had occurred which resulted in the relocation of ACH to ACMC, not in the creation of a "new provider." Ashtabula, 352 F.3d at 1091-1092.

The Sixth Circuit affirmed the District Court's reversal of the Secretary's denial of a new provider exemption to ACMC. The Court held:

> Although the term "provider" is not defined in §413.30(e), its meaning is made clear by referencing related statutes: the term "provider of services" includes a "skilled nursing facility," 42 U.S.C. §1395x(u); "skilled nursing facility," in turn, is "an institution (or a distinct part of an institution)," that is primarily engaged in providing skilled nursing care to its residents, 42 C.F.R. §1395i-3(a). Given these definitions, the term "provider" as used in 42 C.F.R. §413.30(e) refers to a Medicare-certified institution (or Medicare-certified distinct part) that furnishes specified services (here, SNF services). In this case, ACMC represents the "provider of inpatient services" contemplated by § 413.30(e).

Ashtabula, 352 F.3d at 1096. The Sixth Circuit concluded:

> The fact that a circuit split exists on this question indicates that it is a very close call and, in one sense, supports the Secretary's contention that the regulation is ambiguous. However, we conclude that the language of section 413.30(e) has a plain meaning. As the Fourth Circuit held, a "provider" is nothing more than a "business institution that is providing...skilled nursing services." Maryland General, 308 F.3d at 346. Everything about ACMC's facility is new except for the CON rights. It is housed in a new building and has new patients, a new staff, and a new corporate identity. The kind of corporate shenanigans feared by the Secretary did not occur here. Rather, ACMC set up a SNF in its hospital. In order to do so, it purchased a single asset from ACH in the form of a CON for fifteen nursing

> home beds, just as if it had bought a used x-ray machine or kitchen oven. Such a purchase does not make ACMC into ACH repackaged. Accordingly, we hold that ACMC is entitled to "new provider" status pursuant to section 413.30(e).

Ashtabula, 352 F.3d at 1097 (emphasis added).

Thus, the Sixth Circuit and the Fourth Circuit have resolved the dispositive issue in an identical manner: they have looked at the plain meaning of the word "provider" and they have concluded that the mere transfer of CON bed rights does not justify the Secretary's denial of a new provider exemption. The facts in this case are exactly parallel to the facts in Ashtabula and Maryland General: "Everything about [Providence Yakima's] facility is new except for the CON rights." Ashtabula, 352 F.3d at 1097. Therefore, under the plain meaning of the word "provider," the Providence Yakima SNF qualifies for a new provider exemption.

B. Three Other Circuit Courts Of Appeals Have Adopted A Method Of Analysis Which Conflicts With That Of The Fourth Circuit And The Sixth Circuit.

The Ninth Circuit has joined with the First Circuit and the Seventh Circuit in deciding this issue in favor of the Secretary. Providence, 353 F.3d at 665-666. See South Shore Hospital, Inc. v. Thompson ("South Shore"), 308 F.3d 91 (1st Cir. 2002); Paragon Health Network v. Thompson ("Paragon"), 251 F.3d 1141 (7th Cir. 2001). The rationale of all three Circuits is that the language of 42 C.F.R. § 413.30(e) is "vague," and that, therefore, the courts must defer to the Secretary's interpretation of the regulation. Providence, 353 F.3d at 665-

666, quoting Paragon, 251 F.3d at 1148, and South Shore, 308 F.3d at 98.

C. Certiorari Should Be Granted In Order To Permit This Court To Resolve The Direct Conflict Between The Circuit Courts Of Appeals.

This Court is in a position to resolve the direct conflict between the Circuit Courts of Appeals with respect to the SNF new provider exemption issue. Given the fact that this issue has been brought before five Circuits, it is clearly an issue of national application in which there is a need for national uniformity. The Petitioner respectfully requests the Court to grant this Petition so that it may resolve the conflict between the Circuits.

II. Review Is Warranted To Settle The Important Question Of Whether, In Light Of The Court's Holding In United States v. Mead, An Agency's Interpretation Of Its Own Regulation Is To Be Accorded Mandatory Judicial Deference.

In Chevron U.S.A. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984), the Court adopted the principle that courts must defer to an agency's reasonable interpretation of a statute when Congress is silent or leaves ambiguity in the statute that the agency is charged with administering. Id. at 844-85. The Court styled such gaps or ambiguities as "implicit" legislative delegations of rulemaking authority to the agency. Id. at 844.

The Court has also adopted the principle that courts are to "give substantial deference to an agency's interpretation of its own regulations." Thomas Jefferson Univ. v. Shalala, 512

U.S. 504, 512, 114 S. Ct. 2381, 129 L. Ed. 2d 405 (1994) (citing Martin v. Occupational Safety and Health Review Comm'n, 499 U.S. 144, 150-151, 111 S. Ct. 1171, 113 L. Ed. 2d 117 (1991); Lyng v. Payne, 476 U.S. 926, 939, 106 S. Ct. 2333, 90 L. Ed. 2d 921 (1986); Udall v. Tallman, 380 U.S. 1, 16, 85 S. Ct. 792, 13 L. Ed. 2d 616 (1965)). This principle, whose roots stem back to Bowles v. Seminole Rock & Sand Co., 325 U.S. 410, 414, 65 S. Ct. 1215, 89 L. Ed. 1700 (1945), is doctrinely similar to Chevron: "The intention of Congress ... may be relevant in the first instance in choosing between various constructions [of a regulation]. But the ultimate criterion is the administrative interpretation, which becomes of controlling weight unless it is plainly erroneous or inconsistent with the regulation." Id. Like Chevron, Seminole Rock imposes mandatory judicial deference on permissible agency interpretations. And, as in Chevron, an agency's "power authoritatively to interpret its own regulations" under the Seminole Rock doctrine is "a component of the agency's delegated lawmaking powers." Martin, 499 U.S. at 151 (emphasis added). See Ford Motor Credit Co. v. Milhollin, 444 U.S. 555, 566, 100 S.Ct. 790, 63 L.Ed.2d 22 (1980).

Although mandatory judicial deference to agency interpretations (whether of ambiguous statutes or regulations) has indeed become ubiquitous, this Court has recently clarified that Chevron deference is permissible only when the interpretation has the "force of law." Christensen v. Harris County, 529 U.S. 576, 587, 120 S. Ct. 1655, 146 L. Ed. 2d, 621 (2000). According to the Court, "[i]nterpretations such as those in opinion letters – like interpretations contained in policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law – do not warrant Chevron-style deference." Id. at 587. Instead, they are merely "entitled to respect" under the less-exacting deference standard set forth in Skidmore v. Swift & Co., 323 U.S. 134, 140, 65 S. Ct. 161, 89

L. Ed. 124 (1944). In other words, agency interpretations that lack the force of law are to be given the weight shown by "the thoroughness evident in its consideration, the validity of its reasoning, the consistency with earlier and later pronouncements, and all those factors which give it the power to persuade, if lacking the power to control." Id. at 140. This burden of persuasion falls on the agency and not, as with Chevron-style deference, on the regulated party. Christensen, 529 U.S. at 582-83, 587.

In United States v. Mead Corp., 533 U.S. 218, 121 S. Ct. 2164, 150 L. Ed. 2d. 292 (2001), the Court further held that the question of whether an agency interpretation has the "force of law" and therefore qualifies for Chevron-style deference turns on whether "it appears that Congress delegated authority to the agency generally to make rules carrying the force of law, and [whether] the agency interpretation claiming deference was promulgated in the exercise of that authority." Mead, 533 U.S. at 226-27. "[W]here statutory circumstances indicate no intent to delegate general authority to make rules with force of law, or where such authority was not invoked," courts are to defer to an agency interpretation under Skidmore, not Chevron. Id. at 237.

According to Mead, a "very good indicator" of congressional delegation meriting Chevron-style deference is an express statutory authorization to the agency "to engage in the process of rulemaking or adjudication that produces regulations or rulings for which deference is claimed." Id. at 229. In such instances, "[i]t is fair to assume generally that Congress contemplates administrative action with the effect of law when it provides for a relatively formal administrative procedure tending to foster the fairness and deliberation that should underlie a pronouncement of such force." In short, "Chevron should apply only where Congress would want Chevron to apply," and "it is therefore important to determine whether a

plausible case can be made that Congress would want such a delegation to mean that agencies enjoy primary interpretational authority." Id. at 230 n.11 (emphasis added) (quoting Merrill & Hickman, Chevron's Domain, 89 Geo. L. J. 833, 872 (2001)).

Although the Court was not called upon to address the issue head-on, Christensen and Mead logically apply not only when agencies interpret ambiguous statutes, but also when agencies interpret ambiguous provisions of their own regulations. Both Chevron and Seminole Rock are premised on the principle that mandatory judicial deference is permissible when Congress has delegated appropriate lawmaking authority to the agency. If there is doubt that Congress intended to delegate interpretative authority to an agency, the agency simply has no power to fill the interstitial gaps in ambiguous law – regardless if the source of law is statutory or its own regulations. See Mead, 533 U.S. at 229-30.

Moreover, requiring courts to defer to agency interpretations of their own rules would undermine Mead and Christensen. In order to avoid those cases' limitation on the scope of Chevron, an agency can simply graft an ambiguous regulation onto an ambiguous statute, and then in turn clarify the ambiguous regulation through informal interpretations entitled to mandatory Seminole Rock deference. Merrill & Hickman, Chevron's Domain, 89 Geo. L. J. at 900. This not only renders Mead a nullity, but in fact gives "agencies high incentive to rush out barebones, ambiguous rules." Mead, 533 U.S. at 246 (Scalia, J., dissenting). See Thomas Jefferson, 512 U.S. at 525 (Thomas, J., dissenting) ("It is perfectly understandable, of course, for an agency to issue vague regulations, because to do so maximizes agency power and allows the agency greater latitude to make law through adjudication rather than through the more cumbersome

rulemaking process. Nonetheless, agency rules should be clear and definite so that affected parties will have adequate notice concerning the agency's understanding of the law.")

Seminole Rock's mandatory deference is an anachronism and does not square with this Court's recent scaling back of the scope of Chevron. Accordingly, Seminole Rock should be subject to the same limiting principles as Christensen and Mead: interpretations of regulations should be accorded mandatory deference only when they have the force of law; that is, when they were promulgated in the exercise of congressional authority to make law. Cf. Mead, 533 U.S. at 226-27. If the interpretations are not embodied in legislative rules, binding adjudication, or another process showing Congress's intent to delegate lawmaking authority, the interpretation must be reviewed under Skidmore. Merrill & Hickman, Chevron's Domain, 89 Geo. L. J. at 900.

The importance of settling the question of whether Seminole Rock survived Mead is amply demonstrated in this case. Relying on Thomas Jefferson, 512 U.S. at 51, the Ninth Circuit (and the First Circuit before it) held that the Secretary's interpretation of 42 C.F.R. § 413.30(e) was entitled to "substantial deference," and, under this standard, the Secretary was entitled to construe the regulation. The court allowed the Secretary to import its definition of "change of ownership" from the Provider Reimbursement Manual ("PRM") in concluding that a "provider" under Section 413.30(e) "may merely be a collection of segregable assets," and that "bed rights are an essential characteristic of providership." Providence, 353 F.3d at 666. Moreover, the court below pointedly held that it was not the Secretary's burden to prove that his interpretation of Section 413.30(e) was reasonable. "Rather, the burden falls on Providence to show that the Secretary's reliance on the

proffered policy concerns and rationales is unreasonable." Id. at 668. See South Shore, 308 F.3d at 101.

The Ninth Circuit applied this Chevron-style deference even though there is no indication that the Secretary promulgated his interpretation in the exercise of delegated authority to make law. Cf. Mead, 533 U.S. at 226-27. The Medicare Act vests the Secretary with the authority to determine reasonable costs "in accordance with regulations establishing the method or methods to be used," and "such regulations ... may provide for the establishment of limits on the ... costs ... to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v)(1)(A). There can be no dispute, however, that the Secretary's interpretation of Section 413.30(e) was not issued as a regulation and was never subject to notice-and-comment.

Instead, the Secretary's interpretation first came through its agent, the fiscal intermediary, who has no statutory power to deviate from the Secretary's interpretation of his own regulations. See Bethesda Hosp. Ass'n v. Bowen, 485 U.S. 399, 404, 108 S. Ct. 1255, 99 L. Ed. 2d 460 (1988). The sole recourse for the Petitioner – and, indeed, to all providers who are dissatisfied with the amount of Medicare reimbursement – was to appeal the intermediary's decision to the PRRB. 42 U.S.C. § 1395oo(a). The PRRB, however, is an independent, neutral adjudicatory body with no authority to exercise policymaking power. Cf. Martin, at 154-55 (Congress did not delegate authority to interpret regulations to independent Occupational Safety and Health Review Commission). Indeed, the Secretary may at his own discretion affirm, reverse, or modify any ruling of the PRRB without additional input from the affected provider. 42 U.S.C. § 1395oo(f)(1). Like the intermediary, the PRRB has no power to declare the Secretary's

regulations invalid. Bethesda Hosp., 485 U.S. at 406. Nothing in the legislative scheme at issue here permits the Secretary to issue binding interpretations of regulations through the give-and-take of ordinary adjudicative proceedings.

In short, the Secretary's interpretation of Section 413.30(e) did not issue as the result of a reasoned adjudicative proceeding designed to assure due deliberation with respect to the pronouncement. Cf. Mead, 533 U.S. at 230. Instead, the Secretary simply used the PRM – which, under Christensen and Martin, is not deemed to have the force of law – to fill in the purported gaps in the regulation. Given the absence of any indication that Congress intended to give the Secretary the authority to issue interpretations of regulations in this manner, the Secretary's reading of Section 413.30(e), although worthy of some weight, should not be given Chevron-style deference.

In sum, after Christensen and Mead, the ongoing vitality of Seminole Rock's Chevron-style deference is unsettled. If it was the Court's intention to require courts to apply Skidmore deference to an agency's interpretation of its own ambiguous regulation, the court below applied "the wrong decisional framework." Providence, 353 F.3d at 668 (quoting South Shore, 308 F.3d at 101). The burden should be on the Secretary to show why his interpretation of Section 413.30(e) is persuasive. On that basis, this Petition should be granted.

CONCLUSION

For the foregoing reasons, the Petitioner respectfully requests the Supreme Court to grant this Petition for a Writ of Certiorari.

DATED this 28th day of May, 2004.

Respectfully submitted,

Michael Madden
Counsel of Record
BENNETT BIGELOW & LEEDOM, P.S.
1700 – Seventh Avenue
Suite 1900
Seattle, Washington 98101
(206) 622-5511

Attorneys for Petitioner

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Case No. 02-35912

[Filed March 1, 2004]

PROVIDENCE HEALTH SYSTEM - WASHINGTON, dba - Providence Yakima Medical Center, dba Providence Yakima Medical Center Skilled Nursing Facility; PROVIDENCE YAKIMA MEDICAL CENTER; PROVIDENCE YAKIMA MEDICAL CENTER SKILLED NURSING FACILITY, Plaintiffs-Appellees,	)
v.	)
TOMMY G. THOMPSON, Secretary Department of Health and Human Services, Defendant-Appellant.	)

Appeal from the United States District Court
for the Eastern District of Washington, Spokane
D.C. No. CV-01-03060-RHW
Robert H. Whaley, United States District Judge

Before: Dorothy W. Nelson, Alex Kozinski, and M. Margaret McKeown, Circuit Judges.

The members of the panel that decided this case voted unanimously to deny the petition for rehearing. Judges Kozinski and McKeown voted to deny the petition for rehearing en banc. Judge Nelson recommended denial of the petition for rehearing en banc.

The full court has been advised of the petition for rehearing en banc and no active judge has requested a vote on whether to rehear the matter en banc. (Fed. R. App. P. 35.)

The petition for rehearing and the petition for rehearing en banc are denied.

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

Case No. 02-35912

[Filed December 17, 2003]

PROVIDENCE HEALTH SYSTEM - WASHINGTON, dba - Providence Yakima Medical Center, dba Providence Yakima Medical Center Skilled Nursing Facility; PROVIDENCE YAKIMA MEDICAL CENTER; PROVIDENCE YAKIMA MEDICAL CENTER SKILLED NURSING FACILITY,
Plaintiffs-Appellees,

v.

TOMMY G. THOMPSON, Secretary Department of Health and Human Services,
Defendant-Appellant.

Appeal from the United States District Court
for the Eastern District of Washington, Spokane
D.C. No. CV-01-03060-RHW
Robert H. Whaley, United States District Judge

JUDGMENT

APPEAL FROM the United States District Court for the Eastern District of Washington (Spokane).

THIS CAUSE came on to be heard on the Transcript of the Record from the United States District Court for the Eastern District of Washington (Spokane) and was duly submitted.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court, that the judgment of the said District Court in this cause be, and hereby is REVERSED and REMANDED for entry of judgment.

Filed and entered December 17, 2003

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Case No. 02-35912

[Filed December 17, 2003]

PROVIDENCE HEALTH SYSTEM - WASHINGTON, dba - Providence Yakima Medical Center, dba Providence Yakima Medical Center Skilled Nursing Facility; PROVIDENCE YAKIMA MEDICAL CENTER; PROVIDENCE YAKIMA MEDICAL CENTER SKILLED NURSING FACILITY, Plaintiffs-Appellees,	)
v.	)
TOMMY G. THOMPSON, Secretary Department of Health and Human Services, Defendant-Appellant.	)

Appeal from the United States District Court
for the Eastern District of Washington
D.C. No. CV-01-03060-RHW
Robert H. Whaley, United States District Judge

Before: Dorothy W. Nelson, Alex Kozinski, and M. Margaret McKeown, Circuit Judges.

OPINION

D.W. NELSON, Senior Circuit Judge:

The Secretary of Health and Human Services (Secretary) appeals the district court's reversal of the Secretary's decision to deny Providence Health System-Washington (Providence) a "new provider" exemption under 42 C.F.R. § 413.30(e) (1996). We hold that 42 C.F.R. § 413.30(e) is ambiguous. Because the Secretary's interpretation that Providence is not entitled to a new provider exemption due to its acquisition of pre-existing bed rights from Summitview Manor (Summitview) is reasonable, it is therefore entitled to deference. Consequently, we reverse the decision of the district court and direct entry of summary judgment in favor of the Secretary.

I. Factual and Procedural Background

Providence opened as a Medicare-certified skilled nursing facility (SNF) in Yakima, Washington in May 1993. Washington, like many other states, has developed a fairly elaborate methodology for regulating the number of its nursing home beds. *See* Wash. Admin. Code §§ 246-310-350 to 246-310-390 (1992). Under this scheme, Washington closely monitors geographical planning areas in the state in order to determine which areas are "under-bedded" or "over-bedded," relative to the need for medical services. In certain areas, "no [new] beds can be added" until a statutory formula is satisfied. *See* Wash. Admin. Code § 246-310-380(3). Washington also requires Certificate of Need (CON) approval before an entity can perform various health care activities,

including the "construction, development, or other establishment of a new health care facility." Wash. Admin. Code. § 246-310-020(1)(a). Washington law licenses new nursing facility beds only upon issuance of a CON. Previously approved CON nursing facility beds, however, can be purchased or transferred from an existing or closed nursing facility in order to help establish a new facility. In 1990, Providence purchased the rights to operate its twelve beds from an existing nursing facility, Summitview. This transfer of bed rights allowed Providence to obtain a CON, and is the only connection between Providence and Summitview.

Providence's operations were regulated not only by Washington law, but also by the highly technical Medicare program. The Medicare Act, 42 U.S.C. §§ 1395-1395ggg (1996), provides federal funding for various medical services for the elderly and disabled. For the years in question here, it also provides reimbursement for the reasonable costs of certain services provided by SNFs. *See id.* § 1395f(b)(1); 42 C.F.R. § 413.1(a)(2)(ii), (b), (g).[1] Routine service cost limitations (RCLs) are imposed on reimbursement, however, for non-capital per diem costs of patient care. For SNFs, the RCLs are 112% of the industry average of such costs. 42 U.S.C. § 1395yy(a). SNFs that qualify as "new providers," however, can obtain an exemption from the RCLs — and thus

---

[1] Providence sought Medicare reimbursement for the cost-reporting years 1993-1996. For cost-reporting years beginning on or after July 1, 1998, SNFs are no longer reimbursed on a reasonable cost basis and, instead, are reimbursed under a "prospective payment" system. *See* 42 U.S.C. § 1395yy(e)(1), (e)(2)(D)-(E); 42 C.F.R. § 413.1(g)(2)(i).

obtain full reimbursement — for their first three years of operation. 42 C.F.R. § 413.30(e).[2]

In June 1996, Providence applied for cost exemptions from the Health Care Financing Administration (HCFA), the Department of Health and Human Services (HHS) agency that administered Medicare.[3] HCFA denied the exemption. Providence then appealed to the Provider Reimbursement Review Board (PRRB), which affirmed the denial of Providence's exemption request in a unanimous opinion on May 16, 2001. The PRRB determined that Providence was not a new provider as it had "purchased and relocated the operating rights to 12 existing and operational beds from Summitview, and that the transaction was effected by means of a [change of ownership] as set forth under HCFA Pub. 15-1 § 1500.7 and further clarified by the provisions in HCFA Pub. 15-1 § 2533.1." Providence Yakima Med. Ctr. v. Blue Cross and Blue Shield Ass'n, PRRB Hrg. Dec. No. 2001-D32, at 18 (May 16, 2001). The PRRB also determined that Summitview had provided skilled nursing services to its patients in the three years prior to the sale of its bed rights. *Id.* at 19. Therefore, the PRRB concluded that Providence was not a new provider both because a change of ownership (CHOW) had occurred — indicating previous ownership — and because Summitview had provided skilled nursing services in the three-year look-back period of 42 C.F.R. § 413.30(e).

---

[2] The new provider exemption can now be found at 42 C.F.R. § 413.30(d).

[3] The HCFA is now known as the Centers for Medicare and Medicaid Services.

After the HCFA Administrator declined to review the PRRB's decision, Providence sought judicial review in the district court. The district court denied the Secretary's motion for summary judgment and granted summary judgment to Providence sua sponte. It reversed the Secretary's decision, found that the "new provider" exemption unambiguously applied to Providence, and declined to defer to either the Secretary's interpretation of 42 C.F.R. § 413.30(e) or the Secretary's policy rationale for that interpretation.

II. Standard of Review

The district court's grant of summary judgment is reviewed de novo. *Webster v. Pub. Sch. Employees of Wash. Inc.*, 247 F.3d 910, 913 (9th Cir. 2001). Neither party argues that there are disputed factual issues. Rather, this Court must determine "whether the district court correctly applied the relevant substantive law." *Id.* The district court's interpretation of federal regulations is reviewed de novo. *Id.* at 914-15.

Under the Administrative Procedure Act, an agency decision may be reversed if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). "[A]n agency's interpretation of its own regulations" is entitled to "substantial deference." *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512, 114 S. Ct. 2381, 129 L. Ed. 2d 405 (1994). Therefore,

> the agency's interpretation must be given controlling weight unless it is plainly erroneous or inconsistent with the regulation. . . . This broad deference is all the more warranted when, as here, the regulation concerns a complex and highly technical regulatory program [Medicare], in which the identification and

> classification of relevant criteria necessarily require significant expertise and entail the exercise of judgment grounded in policy concerns.

Id. (citations and internal quotation marks omitted). In other words, if "the meaning of [regulatory] language is not free from doubt" — i.e., is ambiguous — "the reviewing court should give effect to the agency's interpretation so long as it is reasonable, that is, so long as the interpretation sensibly conforms to the purpose and wording of the regulations." *Martin v. Occupational Safety & Health Review Comm'n*, 499 U.S. 144, 150-51 (1991) (citations and internal quotation marks omitted).

III. Discussion

A. *42 C.F.R. § 413.30(e) Is Ambiguous*

The critical question here is whether that characteristic of Providence's operations that makes it a provider — the provision of inpatient services — can be said to have been previously owned by Summitview. 42 C.F.R. § 413.30(e) defines "new provider" in the context of the relevant exemption: "A new provider is a provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare under present and previous ownership, for less than three full years." 42 C.F.R. § 413.30(e). We hold that the plain language of 42 C.F.R. § 413.30(e) does not clearly address whether Summitview's ownership of the bed rights it transferred to Providence constitutes previous ownership.

Providence quotes extensively from *Ashtabula County Medical Center v. Thompson*, 191 F. Supp. 2d 884 (N.D. Ohio 2002), in support of its argument that 42 C.F.R.

§ 413.30(e) is unambiguous. The court in *Ashtabula* held that the term " 'provider' is unambiguous and must refer to an institution (or distinct part of an institution), not merely to a characteristic or attribute of such an institution." *Ashtabula County Med. Ctr.*, 191 F. Supp. 2d at 893. The district court also relied heavily on *Ashtabula*'s logic. The statutory definition of "provider" includes a "skilled nursing facility," 42 U.S.C. 1395x(u), which in turn is defined as "an institution (or a distinct part of an institution) which . . . is primarily engaged in providing . . . skilled nursing care." 42 U.S.C. 1395i-3(a). However, simply equating "provider" with "institution," or a "distinct part of an institution," does not remove the ambiguity from the face of the regulation.

Rather, we are persuaded by *Paragon Health Network v. Thompson*, 251 F.3d 1141 (7th Cir. 2001), and *South Shore Hospital, Inc. v. Thompson*, 308 F.3d 91 (1st Cir. 2002), and hold that the interplay of "provider" and "previous ownership" renders the regulation inherently ambiguous as to the critical question at issue in this case. As the Seventh Circuit explained in *Paragon*, there is no commonly understood set of attributes that defines a provider. *See Paragon*, 251 F.3d at 1148. Agreeing with *Paragon*, the First Circuit concluded that the regulation's ambiguity "hinge[d] on the meaning of 'previous ownership.'" *South Shore*, 308 F.3d at 98. The First Circuit further reasoned that "the terms 'provider' and 'institution' are central to an understanding of the exemption, and those terms subsume any number of components, changes in one or all of which might, depending on the context, lead one to deduce that a new provider has (or has not) been created." *Id.*

Here, Providence's attempt to cast 42 C.F.R. § 413.30(e) as unambiguous must fail. One could, and the Secretary does, argue that the provision of services is impossible without bed

rights, and because Summitview provided similar services when it owned the bed rights, Summitview previously owned the essential characteristic of providership that Providence now possesses. One could also argue that Providence is a different facility than Summitview, that numerous elements in addition to bed rights are necessary to provide skilled nursing services, and that Providence's essential providership was never previously owned by Summitview because none of these additional elements of Providence's SNF was previously owned by Summitview. Neither interpretation is plainly foreclosed by the regulation. Because "the regulation is not drawn in blacks and whites but leaves significant gray areas unresolved, it is ambiguous." *Id.*

B. *The Secretary's Interpretation Was Reasonable*

i. *A Change of Ownership*

Because the language of 42 C.F.R. § 413.30(e) is vague, we must defer to the Secretary's reasonable interpretation. *See Thomas Jefferson*, 512 U.S. at 512. The Secretary chose to narrow its determination of Providence's previous ownership to the question of whether the bed rights were previously owned by another SNF or the equivalent of an SNF. This focus on bed rights derives from the Secretary's position that a provider may merely be a collection of segregable assets used to render a specific type of care within an institution. We hold that it was not unreasonable for the Secretary to focus on bed rights, as bed rights are an essential characteristic of providership.

In turn, the Secretary determined that the sale of the bed rights qualified as a CHOW as reflected in its Provider Reimbursement Manual (PRM). PRM-1 § 1500.7 states that a CHOW will occur upon the "disposition of all or some

portion of a provider's facility or assets (used to render patient care) through sale . . . if the disposition affects licensure or certification of the provider entity." PRM-1 § 1500.7 (1985). We hold that the Secretary's application of PRM-1 § 1500.7 to Providence's transaction was a reasonable application of its power to interpret its own regulations.

Providence argues against the application of PRM-1 § 1500.7 on two grounds. First, it states that the only transferred assets were the "intangible" bed rights and that PRM-1 § 1500.7 does not countenance this type of disposition. But "the Secretary, through HCFA, historically has defined change of ownership differently in different contexts, and we see no reason why the Secretary, in the exercise of his broad authority to interpret regulations that he himself has promulgated, cannot choose to apply section 1500.7's dilucidation in this context . . . ." *South Shore*, 308 F.3d at 99. Second, Providence argues that because Summitview is still in existence, Summitview's licensure was not affected. But that position is not supported by the language of PRM-1 § 1500.7. The sale *affected* Summitview's licensure because it reduced the number of Summitview's licensed beds. Providence's attempts to foreclose the application of PRM-1 § 1500.7 fail to take into account that a Medicare CHOW is "a term of art," the "interpretation of [which] lies peculiarly within the compass of the Secretary's expertise." *Id.* at 100.

Providence additionally contends that the PRRB's mention of PRM-1 § 2533.1(E)(1)(b) (1997) was an impermissibly retroactive application of this guideline, which was published in September of 1997, more than a year after Providence submitted its application for new provider status. PRM-1 § 2533.1(E)(1)(b) links CHOWs, including the purchase of the right to operate long-term care beds from a pre-existing

facility, to determinations of previous ownership under 42 C.F.R. § 413.30(e).

Providence fails to appreciate that PRM-1 § 2533.1(E)(1)(b) incorporated existing policy, and overlooks the fact that the PRRB did not hinge its determination solely on PRM-1 § 2533.1(E)(1)(b). First, the PRM provides interpretative advice; it does not constitute legally binding authority. *Phoenix Baptist Hosp. & Med. Ctr. v. Heckler*, 767 F.2d 1304, 1307 (9th Cir. 1985). PRM-1 § 2533 was specifically intended to "integrate[ ] existing policy found in §§ 1500 and 2414.3 to aid providers in understanding what constitutes a change of ownership (CHOW)." HCFA Pub. 15-1, Rev. 400 (09-97). The PRRB was free here to apply the standard in PRM-1 § 2533.1(E)(1)(b) to Providence, even in the absence of the guideline's promulgation, because this interpretative guideline "merely stated [the Secretary's] reading of the old regulations." *Health Ins. Ass'n. of Am. Inc. v. Shalala*, 306 U.S. App. D.C. 104, 23 F.3d 412, 424 (D.C. Cir. 1994); *see also Sentara-Hampton Gen. Hosp. v. Sullivan*, 298 U.S. App. D.C. 372, 980 F.2d 749, 759-60 (D.C. Cir. 1992). Any possible "retroactive effect was completely subsumed in the permissible retroactivity of the agency adjudication." *Health Ins. Ass'n of Am. v. Shalala*, 306 U.S. App. D.C. 104, 23 F.3d 412, 424. Second, the PRRB determined that the transaction was a CHOW as set forth under PRM-1 § 1500.7 "and *further clarified* by the provisions in [PRM-1] § 2533.1." PRRB Hrg. Dec. No. 2001-D32 at 18 (emphasis added). PRM-1 § 2533.1, although briefly mentioned, was not necessary to the PRRB's decision.

ii. *A Narrow Construction of 42 C.F.R. § 413.30(e)*

The PRRB's decision to deny Providence new provider status is also reasonable in light of the policy concerns that

drive the exemption of 42 C.F.R. § 413.30(e). The Secretary's narrow construction of the exemption is supported both by Washington's de facto moratorium on new nursing facility beds, and the policy of preventing initial under-utilization that undergirds 42 C.F.R. § 413.30(e). 44 Fed. Reg. 31,802 (June 1, 1979).

Washington, along with other states, has decided to impose what amounts to a de facto moratorium on nursing beds. These limits reduce the number of new facilities, and ultimately reduce competition. In these moratorium states the Secretary has reasonably decided that no additional benefit is gained in the overall delivery of health care services when beds are merely shifted from one provider to another.[4] The Secretary has determined that an exemption that would reimburse higher costs resulting from such a transfer of bed rights would improperly reimburse costs that are not necessary to the efficient delivery of health services. *See Paragon*, 251 F.3d at 1149-50. Because providers in moratorium states will tend to suffer less from the effects of competition and any initial under-utilization, the Secretary has reasonably determined that they have less of a need for the exemption. *See South Shore*, 308 F.3d at 100.

Providence argues that even if 42 C.F.R. § 413.30(e) is ambiguous, the Secretary's decision is nonetheless invalid. Relying largely on *Ashtabula*, Providence confines its argument to rebutting the Secretary's policy rationales for its interpretation. As the *South Shore* court held, however, *Ashtabula* "erects the wrong decisional framework." *Id.* at

---

[4] This is not to say, however, that if a provider satisfies the relocation requirements under PRM-1 § 2533.1(B)(3), that it is not eligible for an exemption from the cost limits.

101. The burden is not on the Secretary to prove that his interpretation is reasonable. Rather, the burden falls on Providence to show that the Secretary's reliance on the proffered policy concerns and rationales is unreasonable. *See id.* Providence has not met this burden, and the district court erred in following *Ashtabula* and dismissing the Secretary's policy arguments.

42 C.F.R. § 413.30(e) is ambiguous. In his discretion, the Secretary has chosen to interpret the terms "provider" and "previous ownership" broadly in order to narrow the application of the exemption. We hold that the Secretary's decision reasonably conforms to the wording and purpose of this regulation.

C. *Equivalency*

Providence asserts that even if the Secretary's interpretation is correct, it is entitled to new provider status because the transferred beds were not Medicare-certified. 42 C.F.R. § 413.30(e) states that "[a] new provider is a provider of inpatient services that has operated as the type of provider (*or the equivalent*) for which it is certified for Medicare, under present and previous ownership, for less than three full years." 42 C.F.R. § 413.30(e) (emphasis added). Summitview was Medicaid-certified from 1974 to 1991, and has been dually Medicaid- and Medicare-certified since 1992. Medicare and Medicaid nursing facilities provide a similar range of basic services. *South Shore*, 308 F.3d at 106. Further, the PRRB also made a factual determination that Summitview had indeed rendered skilled nursing services at its facilities during the three-year look-back period prior to the sale of the bed rights, thereby precluding an application of the exemption under 42 C.F.R. § 413.30(e). Providence did

not challenge this factual determination on appeal. We therefore uphold the PRRB's equivalency determination.

REVERSED and REMANDED for entry of judgment.

APPENDIX D

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON

Case No. CY-01-3060-RHW

[Filed July 25, 2002]

PROVIDENCE HEALTH SYSTEM - WASHINGTON, *et. al.*, Plaintiffs,	)
v.	)
TOMMY G. THOMPSON, Secretary, DEPARTMENT OF HEALTH and HUMAN SERVICES, Defendant.	)

ORDER DENYING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

Before the Court is Defendant's Motion for Summary Judgment (Ct. Rec. 14). Oral argument was heard on July 24, 2002. Plaintiff Providence Health System-Washington ("Providence") was represented by Stephen Pentz. Defendant Tommy G. Thompson, Secretary of Department of Health and Human Services ("Secretary"), was represented by Aaron Brown and William Beatty.

I. FACTS

Plaintiff Providence brought this action against Defendant Secretary, seeking judicial review of a final administrative agency decision by the Provider Reimbursement Review Board ("PRRB") denying Plaintiff's request to be classified as a "new provider" under 42 C.F.R. § 413.30(e). Defendant now moves for summary judgment.

Plaintiff Providence is a non-profit, acute care hospital, which is owned and operated by the Sisters of Providence Health Systems, and located in Yakima, Washington. On July 31, 1990, the Sisters of Providence, which operates Plaintiff, purchased a certificate of need ("CON") bed allocation right to Summitview Manor's ("Summitview") licensed bed rights. Summitview is another nursing home in Yakima. Plaintiff used the bed allocation rights to 12 of the 40 bed rights it purchased from Summitview to establish its new skilled nursing unit ("SNU" of "SNF"). Plaintiff and Summitview are separate and unrelated health care institutions.[1] Under Washington law, Plaintiff was required to obtain a certificate of need from the State of Washington Department of Health, pursuant to Wash. Rev. Stat. 70.38. A certificate of need was required for this project because the construction of the skilled nursing unit constituted establishment of a "new health care facility" under Wash. Rev. Stat. 70.38.105(4)(a). The

---

[1] Specifically, Plaintiff is located approximately 2 miles away from Summitview; there is no operational relationship between Plaintiff and Summitview; there was no transfer or assignment of Summitview's nursing home license to Plaintiff; there was no transfer of personnel, equipment, or supplies from Summitview to Plaintiff; and there was no transfer of patients from Summitview to Plaintiff. (Ct. Rec. 17.)

purchase and transfer of the certificate of need rights were not subject to certificate of need review under Washington law.[2]

Provider commenced operations in May 1993 and received its Medicare certification as a skilled nursing facility effective May 13, 1993. Provider's skilled nursing unit is licensed as a nursing home by the State of Washington Department of Social and Health Services ("DSHS") pursuant to R.C.W. chapter 18.51.

II. PROCEDURAL BACKGROUND

In a letter dated June 12, 1996, Plaintiff requested its fiscal intermediary, Blue Cross of Washington and Alaska, and the Health Care Financing Administration ("HCFA") to grant its skilled nursing unit a new provider exemption for fiscal year ending December 31, 1993, and the three following cost reporting periods (including 1996), pursuant to 42 C.F.R. § 413.30(e). After determining that Plaintiff does not qualify as a "new provider," Blue Cross of Washington and Alaska ("Intermediary") forwarded Plaintiff's exemption request to the Health Care Financing Administration. The Health Care Financing Administration denied Plaintiff's request for the new provider exemption providing the following reasons: (1) Plaintiff's skilled nursing unit "was established due to the purchase and relocation of 12 beds" from Summitview; (2) since Summitview was an "equivalent provider of skilled nursing and rehabilitative services," Plaintiff's skilled nursing unit was not a new provider; and (3) it was reasonable to infer from the Plaintiff's lack of

---

[2] This is the Plaintiff's position. The Government asserts that the transfer of certificate of need beds was subject to certificate of need regulations.

documentation of the names and home addresses of patients at Summitview and the skilled nursing unit that relocation did not result in a substantial change in the population served or the primary service area.

Plaintiff filed a request for a hearing with the Provider Reimbursement Review Board on August 22, 1997. On May 16, 2001, the Provider Reimbursement Review Board determined that Plaintiff's skilled nursing facility was not entitled to an exemption as a new provider from Medicare skilled nursing facility cost limits for Providence's cost-reporting periods ending December 31, 1993-96. The Provider Reimbursement Review Board decided that the purchase of certificate of need bed allocation rights was a change of ownership ("CHOW") and a relocation of those bed rights to Plaintiff's skilled nursing facility.

III. STANDARD OF REVIEW

Summary judgment is appropriate if the "pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). When considering a motion for summary judgment, a court may neither weigh the evidence nor assess credibility; instead, "the evidence of the non-movant is to be believed, and all justifiable inferences are to be drawn in his favor." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986). A fact is "material" only if its resolution will affect the outcome of the lawsuit. *Id.* at 248. In most civil cases, the Court must decide whether the evidence is such that "reasonable jurors could find by a preponderance of the evidence that the [nonmoving party] is entitled to a verdict" or whether the evidence is "so one-sided that [the moving

party] must prevail as a matter of law." *Id.* at 252. Rule 56(c) "mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-25 (1986).

The Provider Reimbursement Review Board's decision must be reviewed under the standard established by the Administrative Procedure Act ("APA"). 42 U.S.C. § 1395oo(f)(1) (1996). Under the APA, agency decisions may only be set aside if they are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or are "unsupported by substantial evidence in a case . . . reviewed on the record of an agency hearing provided by statute." 5 U.S.C. § 706(2)(A), (E); *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 413-15 (1971). The Court may consider evidence in the record as a whole. *Queen City Home Health Care Co. v. Sullivan*, 978 F.2d 236, 243 (6th Cir. 1992).

An agency's interpretation of the statutes it administers is entitled to great deference. *Chevron, U.S.A., Inc. v. Natural Res. Def. Council Inc.*, 467 U.S. 837, 843-44 (1984). In cases where an agency's interpretation of its own regulations is at issue, increased deference is warranted, and the agency's interpretation should be entitled to "controlling weight" unless it is "plainly erroneous or inconsistent with the regulation." *Thomas Jefferson Univ. Hosp. v. Shalala*, 512 U.S. 504, 512 (1994). Deference is especially warranted where an agency regulation "concerns 'a complex and highly technical regulatory program,'" such as Medicare. *Id.* at 512. However, a district court has a duty to review an agency's interpretation of its own regulations, and should reverse an

agency determination where "an 'alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent at the time of the regulation's promulgation.'" *Id.* An agency's interpretation of its own regulation is entitled to deference only when the language of the regulation is ambiguous. *Christensen v. Harris City,* 529 U.S. 576, 588 (2000).

IV. DISCUSSION

The only issue before the Court is whether Plaintiff's skilled nursing facility established by Providence in Yakima is a "new provider" under 42 C.F.R. § 413.30(e),[3] thus qualifying for an exemption from the Medicare "routine cost limits."

A. Medicare and the Washington Certificate of Need Program

In 1965, Congress enacted the Medicare program, a federally funded and administered health insurance program for the elderly and certain disabled persons. *See* 42 U.S.C. § 1395, *et seq.* (1965). The Secretary administers the Medicare program through Health Care Financing Administration. Under the Medicare program, a skilled nursing facility can be reimbursed for the reasonable costs of the services it provides pursuant to 42 C.F.R. § 1395x(v)(10(A). Since 1972, Congress has refined the Medicare program. 42 U.S.C. § 1395x(v)(1)(A) was amended

---

[3] Effective September 7, 1999, the Secretary revised 42 C.F.R. § 413.30 and, in doing so, moved the new provider exemption from subsection (3) to subsection (d) of the rule. Since the prior codification was in effect during the time periods for this case, all references will be to the prior regulation.

to exclude from the definition of reasonable cost any costs "found to be unnecessary in the efficient delivery of needed health services." The Health Care Financing Administration was also empowered to establish limits or caps on costs necessary for the delivery of health services. The Secretary has adopted numerous regulations which provide exemptions to reimbursement limits, including the "new provider" exemption at issue in this case.

In addition to federal requirements, health care facilities are also subject to state laws. In Washington, health care providers must obtain a certificate of need, basically a license from the appropriate agency, before undertaking certain activities. Pursuant to the Washington certificate of need statute, the Department of Health ("DOH") developed a nursing home bed need methodology to assist it in determining whether there is a need for new nursing home beds in the State of Washington. In implementing its methodology, the Department of Health set forth a policy under Washington Administrative Codes ("WAC") 246-310-350 and WAC 246-310-390, which permits previously-approved certificate of need nursing home bed allocation rights to be transferred from an existing or a closed nursing home to a party that wishes to establish a new nursing home.

In order for Plaintiff to obtain approval to construct a new nursing home from Department of Health, it was necessary for the Provider to obtain certificate of need nursing home bed allocation rights from an existing or closed nursing home. Washington State regulates the size of the market for skilled nursing facility services in Yakima County by controlling the number of skilled nursing facility beds available and requiring providers to get certificate of need approval for certain transactions. (Ct. Rec. 15.) Plaintiff could have purchased these rights from a nursing home located in any county of the

State of Washington. Plaintiff chose to purchase these rights from Summitview, an existing nursing facility located in Yakima County. On March 20, 1992, the Department of Health approved Plaintiff's certificate of need application and transferred ownership of the right to operate nursing home beds from Summitview to Plaintiff.

B. Interpretation of a "New Provider"

A "new provider" is defined in the Medicare regulations as "[a] provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years." 42 C.F.R. § 413.30(e). In the Provider Reimbursement Manual, a "new provider is an institution that has operated in the manner for which it is certified in the program (or the equivalent thereof) under present and previous ownership for less than three full years. Provider Reimbursement Manual, Part 1, § 2604.1.

Plaintiff maintains that the term "provider" means a physical facility or institution according to the plain language of the regulation. (Ct. Rec. 17.) In support of its position, Plaintiff cites to definitions found elsewhere in Medicaid statutes. Namely, the term "provider of services" is defined as "a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, [or] hospice program." 42 U.S.C. § 1395x(u). The term "skilled nursing facility" is defined as "an institution (or a distinct part of an institution)" which provides skilled nursing care. 42 U.S.C. § 1395i-3(a). In the Provider Reimbursement Manual, the term "new provider" is defined as "an institution that has operated in the manner for which it is certified in the program (or the equivalent thereof) under present and previous ownership for less than three full years."

Provider Reimbursement Manual, Part 1, § 2604.1. Based on these definitions and the common usage of word, the term "provider" was found to be unambiguous in *Ashtabula County Medical Center v. Thompson*, 191 F. Supp. 2d 884 (N.D. Ohio 2002). The court in *Ashtabula* interpreted the plain meaning of the term "provider" to refer to the institution applying for the exemption, not merely its intangible characteristics or attributes (as in certificate of need right purchased from another Skilled nursing facility) which allowed it to come into existence. *Id.* at 893.

Defendant has taken the position that the provision "operated . . . under present and previous ownership" under 42 U.S.C. section 413.30(e) does not require that a skilled nursing facility have a "physical" connection with another facility. Indeed, Defendant argues that "the CON [certificate of need] bed allocation rights for the 12 beds establish a clear institutional connection between Summitview and Providence." (Ct. Rec. 15.)

This Court determines that the term "provider" can only be capable of one meaning, and finds that the Provider Reimbursement Review Board's decision was contrary to the plain meaning of the regulation. The other case construing this term, *Paragon Health Network v. Thompson*, 251 F.3d 1141 (7th Cir. 2001), justifies its finding that the term "provider" is ambiguous by its difficulty in drawing the line between the same provider and a new provider. *Id.* at 1148. The examples provided in *Paragon* compare existing providers which changed characteristics with a new provider. *Id.* This analysis is not persuasive to demonstrate that a provider could mean anything less than an institution or part of an institution. *Id.* at n.8. Accordingly, this Court finds that the term "provider" is unambiguous, and Plaintiff did not

become a "provider" for purposes of 42 C.F.R. § 413.30(e) until it had an institution in May 1993.

C. Whether Plaintiff was a change of ownership ("CHOW") from Summitview

The Court must first determine whether the Board's decision that the transfer of certification of need rights constituted a change of ownership was arbitrary and capricious. If the Court finds that there has been a change of ownership, the next step of inquiry would be to determine whether Plaintiff acted as the equivalent of a skilled nursing facility.

Defendant argues that the Provider Reimbursement Review Board appropriately concluded that Plaintiff was a change of ownership rather than a "new provider." (Ct. Rec. 15.) Defendant makes two main arguments in support of its position. Defendant argues that the 12 beds that Plaintiff purchased from Summitview represents the transfer of a significant asset and, thus, amounts to a change of ownership. (Ct. Rec. 15) (citing Provider Reimbursement Manual § 1500.7) ("Disposition of all or some portion of a provider's facility or assets (used to render patient care) through sale . . . affects the licensure or certification of the provider identity). This Court should reject Defendant's argument. First, when considered in combination with other start-up costs that Plaintiff could have incurred, Plaintiff's certificate of need bed rights to 12 beds was not "significant."[4] Second, contrary to Defendant's position, WAC § 246-310-044 does not support Defendant's assertion that Washington State considers certificate of need bed rights to be a significant asset by

[4] The Defendant submits that the price per bed is $4,300.

requiring certificate of need review for sales of bed allocation rights. Instead, WAC § 246-310-044 governs exemptions from requirements for a certificate of need for nursing home bed replacements. *See* WAC § 246-310-044.

Second, Defendant argues that Plaintiff's purchase of bed rights from Summitview was a change of ownership because "it affected Washington State's licensure or certification of Summitview." (Ct. Rec. 15.) In a case that is highly analogous to the instant case, the District Court of Massachusetts adopted the following reasoning:

> the DON [Massachusetts equivalent of Washington's certification of need] . . . were at best an intangible asset because it only evidenced the "right to create and operate nursing beds." The DON rights had some residual value only because the State had instituted a cap on the number of beds that could be licensed within the state . . . [the seller of the certificate of need bed rights] was like a "totalled vehicle" with some parts being sold from the carcass. Thus, the receiver was merely selling available assets to generate funds to pay creditors. Hence, the sale of the intangible DON rights in 1994 did not affect the licensure and certification of [the seller of the certificate of need bed rights] within the meaning of section 1500.7 since licensure and certification was lost due to other reasons.

South Shore Hospital v. Thompson, 204 F. Supp. 2d 76, 82 (D. Mass. 2002). Here, there is no showing that Summitview lost its license or certification upon transferring its certification of need bed rights to Plaintiff. Thus, the Government's argument that the transfer of the bed rights affected Summitview's license status is not compelling.

Indeed, the fact that Summitview is an existing and operating facility lends even more support to the argument that Plaintiff was not a change of ownership from Summitview.

Plaintiff, on the other hand, argues that there was no change of ownership because the only connection between Plaintiff and Summitview is Plaintiff's purchase of certificate of need beds. (Ct. Rec. 17.) Plaintiff further supports its assertion with the following facts: "(1) the Secretary's original denial of Providence Yakima's request for a new provider exemption did not mention the change of ownership rationale, and (2) for the purposes of Medicare certification and cost reporting, the Secretary has treated the Providence Yakima SNF [skilled nursing facility] as a new provider, not as the continuation of an existing provider through a change of ownership." (Ct. Rec. 17.) Indeed, health care providers in moratorium states that purchase certificate of need rights from unrelated providers "fit comfortably within the language and purpose of the new provider exemption." *Ashtabula*, 191 F. Supp. 2d at 897.

D. Reasonableness of Agency's Interpretation

As outlined above, the case for finding the term "provider" as unambiguous is stronger than a finding that the term is ambiguous. Since an agency's interpretation of its own term is entitled to deference only if the term is ambiguous, the Court need not analyze whether the Secretary's interpretation was arbitrary or capricious. *See Christensen*, 529 U.S. at 588, *Citizens to Preserve Overton Park*, 401 U.S. at 413-15. Nevertheless, the weight of the policy arguments are in favor of finding that the Secretary's interpretation of the new provider was arbitrary and capricious.

Defendant argues that Washington State's decision to impose a moratorium on the creation of nursing beds indicates that no new beds were needed. (Ct. Rec. 15.) *Ashtabula* and *Paragon* confront this issue directly. Both district courts found that the precise reason for each state's limitation of the certification of need beds was uncertain and not necessarily related to the standard of necessity imposed by section 1395x(v)(1)(A). *Ashtabula*, 191 F. Supp. 2d at 895, *Paragon*, 191 F.Supp. 2d at 1150.

Defendant also advances the argument that since Plaintiff had a referral source, namely Providence Hospital, it didn't experience the same type of start-up costs that the "new provider" exemption was intended to address. (Ct. Rec. 15) (citing *Paragon*, 251 F.3d at 1149, *see also Maryland Gen. Hosp. Transitional Care Ctr. v. Blue Cross & Blue Shield Assoc.*, Case No. PRRB 99-D69, 1999 WL 33105616 (HCFA Admin. Nov. 22, 1999). The Government has produced evidence that Plaintiff's occupancy during each of the years for which it requested an exemption was above 80%. (Ct. Rec. 15.) Furthermore, the Seventh Circuit has found that a provider who creates a new facility and moves services to it does not produce a benefit to the overall delivery of health services if the new facility provides the same services to the same populace as the old one. *Paragon*, 251 F.3d at 1150. Yet, this Court should not place great weight on this factor. *C.f. Ashtabula*, 191 F. Supp. 2d at 894 ("Policy arguments going to the question of whether the specific costs claimed by ACMC's SNF [skilled nursing facility] are unreasonable or unnecessary in the efficient delivery of needed health services are only indirectly relevant.").

E. Relocated Provider

The Defendant takes a negative inference from Plaintiff's failure to supply the information necessary for the Center for Medicare and Medicaid Services ("CMS") to determine Plaintiff's eligibility for new provider status as a relocated provider. Under section 2604.1 of the Provider Reimbursement Manual, a provider that relocates "may be granted new provider status where the normal inpatient population can no longer be expected to be served at the new location." The Court in *Paragon* held that the same-cities-and-towns standard[5] to find that a relocated skilled nursing facility is not serving a substantially different inpatient population is not arbitrary or capricious. *Paragon*, 251 F.3d at 1152. Defendant speculates that Plaintiff's failure to provide this information was because there was no substantial change in the population served or in the primary service area; this is not persuasive. The Court's determination of whether Plaintiff was a new provider under 42 C.F.R. § 413.30(e) is not affected by Plaintiff's decision not to apply for an entirely different Medicare exemption.

Accordingly, IT IS HEREBY ORDERED:

1. Defendant's Motion for Summary Judgment **(Ct. Rec. 14)** is **DENIED.**

2. This case is **REMANDED** to the Provider Reimbursement Review Board for a determination of the reimbursements owed to Plaintiff.

---

[5] *I.e.*, if the relocated provider's current patients came from the same cities and towns as at its old location, then the exemption will be denied.

IT IS SO ORDERED. The District Court Executive is hereby directed to enter this order and to furnish copies to counsel and close the file.

DATED this 25 day of July, 2002.

/s/
ROBERT H. WHALEY
United States District Judge

APPENDIX E

PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

2001-D32

DATE OF HEARING
November 2-3, 2000

Cost Reporting Periods Ended-
December 31, 1993, December 31, 1994,
December 31, 1995, December 31, 1996

CASE NOS. 97-2651, 97-2652, 97-2653, 97-2654

INDEX

Issue 2

Statement of the Case and Procedural History 2

Provider's Contentions 5

Intermediary's Contentions 10

Citation of Law, Regulations & Program Instructions . . 16

Findings of Fact, Conclusions of Law and Discussion . . 17

Decision and Order 20

ISSUE:

Did the Health Care Financing Administration ("HCFA") properly deny the Provider's request that its skilled nursing unit ("SNU") receive an exemption from the routine cost limits ("RCLs") as a new provider under 42 C.F.R. § 413.30(e)?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Provident Yakima Medical Center ("Provider") is a non-profit, acute care hospital which is owned and operated by the Sisters of Providence Health Systems.[1] The Provider is located in Yakima, Washington, which is part of the Yakima County long-term care planning area as designated by the State of Washington, Department of Health ("DOH"). The sole issue in dispute for this appeal involves the Provider's 12-bed skilled nursing unit ("SNU") which commenced operations in May of 1993, and received its Medicare certification as a skilled nursing facility ("SNF") effective May 13, 1993. By letter dated June 12, 1996, the Provider requested an exemption to the Medicare SNF routine service cost limits as a new provider under the regulatory provisions of 42 C.F.R. § 413.30(e) for the fiscal years ended ("FYE") December 31, 1993 through December 31, 1996. [2] On January 13, 1997, Blue Cross of Washington and Alaska[3]

---

[1] The Provider was formerly known as "St. Elizabeth Medical Center."

[2] See Provider Exhibit P-1/Intermediary Exhibit I-41.

[3] The Intermediary is a subcontractor of the Blue Cross and

("Intermediary") forwarded the Provider's request to HCFA with the recommendation that the request be denied.[4] HCFA reviewed the information submitted with the Provider's exemption request and, by letter dated February 24, 1997,[5] HCFA notified the Intermediary that the Provider's request was denied stating the following:

> We have reviewed the information submitted with the request of Providence Yakima Skilled Nursing Unit (PY), Provider Number 50-5481, for an exemption to the Medicare skilled nursing facility routine service cost limits . . . .
>
> A new provider exemption would be granted to those providers of inpatient services that have operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and/or previous ownership, for less than 3 full years. In this regulation [42 C.F.R. § 413.30(e)] the phrase ". . . has operated as the type of provider. . ." refers to whether or not, prior to certification, the institution or institutional complex engaged in providing residents skilled nursing care and related services for residents who required medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons as identified in 42 C.F.R. § 409.33(b) and (c), and did not primarily care and treat residents with mental diseases. Therefore, an exemption is

---

Blue Shield Association and currently operates under the name of Premera Blue Cross.

[4] See Provider Exhibit P-2/Intermediary Exhibit I-42.

[5] See Provider Exhibit P-3/Intermediary Exhibit I-34.

granted based upon the functioning of the entire institution or institutional complex, not just the Medicare certified distinct part . . . .

The key to understanding HCFA's regulations and policy concerning new provider exemptions is recognizing that we look at the operation of the institution or institutional complex under both "past and present ownership" exclusive of specific provider numbers, names, location, etc., since these are subject to change, to determine if and when skilled nursing and/or rehabilitative services were performed.

The result is that both Medicare SNFs and Medicaid nursing facilities (NFs) are required to provide, directly or under arrangements, the same basic range of services . . . This range of services includes those nursing services and specialized rehabilitative services needed to attain or maintain each resident's highest practicable physical, mental, and psychosocial well-being. Therefore, the range of services for which a Medicaid NF must provide to be certified includes the same types of services as are offered in a SNF that is certified for Medicare. Consequently, a NF, operating as of October 1, 1990, is considered to be an equivalent provider of skilled nursing or rehabilitative services, by meeting the requirements for certification, effective October 1, 1990, specified in the regulations at 42 C.F.R. Part 483; Subpart B, Requirements for Long-Term Care Facilities.

Given this context, PY became Medicare certified May 13, 1993. However, PY, was established due to the purchase and relocation of 12 beds from Summitview Manor located at 3905 Knobel, Yakima,

Washington to 110 South 9th Avenue, Yakima, Washington on May 13, 1993. Under past ownership, the institution known as Summitview Manor operated as a NF, Provider Number 50A142 since February 11, 1974 and as a SNF, Provider Number 50-5409 since January 11, 1992. Therefore, Summitview Manor operated as an equivalent provider of skilled nursing and rehabilitative services. This purchase and relocation of 12 beds from Summitview Manor was approved by the State of Washington, Department of Health on March 20, 1992, CON No. 1065.

Section 2604.1 of HCFA Pub. 15-1 allows for an exemption based upon a relocation whereby the normal inpatient population can no longer be expected to be served at the new location. The service area identified by the State is known as Yakima County. On February 7, 1997, HCFA requested the full name and home address of all patients admitted to and residing at Summitview Manor in the two years prior to the relocation of beds to PY. We also requested the full name and home address of all patients admitted to and residing at PY since it began operating in May of 1993 until the date of the exemption request, June 12, 1996. PY chose not to forward this documentation to HCFA because it believed that the relocation did not result in a substantial change in the population served or in the primary service area.

Accordingly, the provider does not qualify for a new provider exemption because;

1. PY became Medicare certified May 13, 1993. However, PY, was established due to the purchase and relocation of 12 beds

from Summitview Manor located at 3905 Knobel, Yakima, Washington to 110 South 9th Avenue, Yakima, Washington on May 13, 1993. This purchase and relocation of 12 beds from Summitview Manor was approved by the State of Washington, Department of Health on March 20, 1992, CON No. 1065.

2. Under past ownership, the institution known as Summitview Manor operated as a NF, Provider Number 50A142 since February 11, 1974 and as a SNF, Provider Number 50-5409 since January 11, 1992. Therefore, Summitview Manor operated as an equivalent provider of skilled nursing and rehabilitative services.

While the Provider was not granted approval for an exemption, it was permitted to apply for an exception to the routine cost Limits ("RCLs") as provided in 42 C.F.R. § 413.30(f). The Provider requested and received relief from the RCLs through the exception provision of atypical services for the FYEs December 31, 1993, 1994 and 1995. No exception relief has been requested by the Provider for the FYE December 31, 1996.[6] Even with approval of the exception to the RCLs, the Provider experienced a reduction in Medicare reimbursement of approximately $1,430,000 for the four fiscal years in contention.

The Provider appealed HCFA denial of its new provider exemption request to the Provider Reimbursement Review

---

[6] See Intermediary's Position Paper at 27-28

Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The Provider was represented by Stephen I. Pentz, Esquire, of Bennett Bigelow & Leedom, P.S. The Intermediary's representative was Behaard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS

The Provider contends that it is entitled to an exemption from the Medicare RCLs as a new provider pursuant to the definitions set forth in the regulatory and manual provisions which state the following:

> A provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years.

42 C.F.R. § 413.30(e).

The regulatory definition is further refined in the Provider Reimbursement Manual ("HCFA Pub. 15-1") as follows:

> A new provider is an institution that has operated in the manner for which it is certified in the program (or the equivalent thereof) under present and previous ownership for less than three full years.

HCFA Pub. 15-1 §2604.1 (emphasis added).

The Provider notes that HCFA Pub. 15-1 § 2604.1 defines a "new provider" as an institution. This term implies a physical facility or building. This same connotation is reflected in the Medicare statute at 42 U.S.C. § 1395i-3(a) which defines a

"skilled nursing facility" as "an institution (or a distinct part of an institution)" which provides skilled nursing care. The Provider further points out that HCFA's long-standing policy has been to focus on "the institution or institutional complex" in determining whether to grant a new provider exemption. Accordingly, where there is no continuity or connection between two institutions or institutional complexes, a provider is legally entitled to a new provider exemption.

The Provider insists that the determination of whether a provider is a "new provider" must focus upon the operations of the provider as a physical institution or facility within the immediately preceding three-year period. The facts unequivocally establish that the Provider's SNU did not as a "facility" or an "institution," operate as a SNF within the three-year period preceding the commencement of operations. The SNF was a physically-new facility which was established pursuant to a certificate of need ("CON") which authorized the establishment of a new nursing home. In order to establish its hospital-based SNF, the Provider was required to obtain a CON from DOH because the establishment of the SNF constituted the establishment of a "new health care facility" (i.e., a new nursing home) under Washington Law.[7]

The Provider asserts that HCFA and the Intermediary seriously mischaracterized the State of Washington's CON law by stating that the CON statute was expanded in 1992 to include the "relocation" or "conversion" of hospital beds (i.e. acute care to SNF). The Provider argues that no such change occurred in Washington's CON law, either in 1992 or around that time. For many years before 1992 (and to this date), the

---

[7] See Provider Exhibits P-24 and P-25.

following has been subject to CON review under the Revised Code of Washington ("RCW"):

> A change in bed capacity of a health care facility which increases the total number of licensed beds or redistributes beds among acute care, nursing home care, or boarding home care if the bed redistribution is to be effective for a period in excess of six months.

RCW 70.38.105(4)(e).

The Provider believes that this may be the provision that HCFA and the Intermediary alluded to in the Intermediary's position paper. However, the Provider contends that this provision was not added or changed in 1992 and, more significantly, it was not the reason that the Provider was required to obtain a CON to construct and operate its SNF. The Provider was required to obtain a CON because of the provision set forth under RCW 70.38.105 (4)(a) which requires a CON for the "establishment of a new health care facility."[8] The Provider submitted a CON application to DOH on April 17, 1991, which was amended on September 20, 1991, requesting permission to establish a new 12-bed hospital-based SNF.[9] On March 20, 1992, DOH issued CON No. 1065 to the Provider (formerly known as St. Elizabeth Medical Center) authorizing the construction of a new nursing home.[10] The Provider constructed a new 12-bed facility which opened in May of 1993.

---

[8] See Provider Exhibit P-24.

[9] See Provider Exhibits P-6 and P-7.

[10] See Provider Exhibit P-9.

Pursuant to the Washington CON statute established under the Washington Administrative Code ("WAC"), DOH has developed a nursing home bed need methodology to assist it in determining whether there is a need for new nursing home beds in the State of Washington. In implementing the methodology, DOH has a policy set forth under WAC 246-310-350 and WAC 246-310-390 which permits previously-approved CON nursing home bed allocation rights to be transferred from an existing or a closed nursing home to a party that wishes to establish a new nursing home.[11] In order to obtain DOH approval to construct a new nursing home, it was necessary for the Provider to obtain CON nursing home bed allocation rights from an existing or closed nursing home. While these rights could have been purchased from a nursing home located in any county in the State of Washington, the Provider chose to purchase the bed allocation rights from Summitview Manor ("Summitview"), an existing nursing home which is located in the same county as the Provider (Yakima County). The purchase of the bed allocation rights is reflected in an Asset Transfer Agreement dated July 31, 1990.[12]

Contrary to HCFA's determination, the Provider contends that the transfer of CON bed allocation rights from Summitview did not constitute the relocation of an existing Medicare certified facility. While HCFA's entire decision is premised on the relocation of an existing provider, the Provider asserts that this premise is incorrect both as a factual matter and as a legal matter. The Provider argues that the evidence in the record establishes that the only connection

---

[11] See Provider Exhibit P-25.

[12] See Provider Exhibit P-8.

between the Provider and Summitview is the transfer of bed allocation rights, and that this transfer did not involve the relocation or continuation of Summitview at the Provider's campus. The Provider and Summitview continue to be located approximately two miles away from one another, and there has never been any legal or operational relationship between the two entities. Neither entity, or any of their affiliated or related legal entities, has ever had any ownership, operational or management interest in the other entity. The Provider further advises that there was no transfer or assignment of Summitview's nursing home license to the Provider, nor was there any transfer of personnel or operating assets. In summary, the only connection between Summitview and the Provider's SNF was the transfer of intangible CON bed allocation rights.

The Provider also contends that the CON bed allocation rights transferred from Summitview did not relate to Medicare-certified beds and, therefore, there was no relocation or continuation of Medicare-certified beds or of a Medicare certified SNF. Based on the testimony of the Provider's witnesses,[13] the CON allocation rights transferred to the Provider related to beds which were located in Summitview's 87-bed residential or light care building. At the time of the Asset Transfer Agreement on July 31, 1990, Summitview was not Medicare-certified. Summitview did not become Medicare-certified until January 1, 1992, and did not admit its first Medicare patient until June 1, 1992. Upon becoming Medicare certified, Summitview designated only 27 beds as Medicare certified. Although Summitview was Medicare-certified when the CON was issued, the Provider insists that the CON bed allocation rights transferred from Summitview

---

[13] Tr. Vol.1 at 43-44 and 129-133.

did not relate to the beds that were Medicare-certified. Therefore, there was not, and there could not have been, a relocation or continuation of Medicare-certified beds or a Medicare-certified SNF.

The Provider further argues that, factually or legally, there was no change of ownership ("CHOW") involving either Summitview or Summitview's nursing home beds. In further support of the denial of the Provider's exemption request, HCFA and the Intermediary argue that the alleged "relocation" of nursing home beds from Summitview to the Provider constituted a CHOW under HCFA Pub. 15-1 § 1500.7. Since Summitview had been operated as a SNF under previous ownership in the prior three years, it was concluded that the Provider was not entitled to obtain a new provider exemption. The provisions of HCFA Pub. 15-1 § 1500.7 state that a "'disposition of all or some portion of a provider's facility or assets (used to render patient care) through sale, scrapping, involuntary conversion, demolition or abandonment" constitutes a CHOW "if the disposition affects licensure or certification of the provider entity." The Provider maintains that, in the instant case, there was only a transfer of "intangible" CON bed allocation rights which is not the type of disposition ofpropertywhich §1500.7 is intended to cover. Further, no event occurred which affected the "license or certification of the provider entity" as contemplated by the manual provisions.

The Provider argues that the CHOW provisions apply when a provider ceases to participate in the Medicare program, and that the filing of a final report by the provider is required. In the instant case, Summitview remained a fully-licensed Medicare-certified nursing home after the transfer of the bed allocation rights, and neither the Intermediary nor HCFA required Summitview to file a final cost report. The Provider

believes that the Intermediary and HCFA retrospectively constructed their CHOW argument in an attempt to rationalize their argument that there has been a "relocation" of nursing home beds from Summitview to the Provider's SNF. The Provider asserts that there was no CHOW, either of Summitview's facility or of its nursing home beds. The Washington DOH did not approve any CHOW, but rather approved the establishment of a "new health care facility."

The Provider points out that HCFA and the Intermediary have, from the outset, treated the Provider's SNF as a new provider, and not as the continuation of an existing provider. The record shows that the Provider's SNF was surveyed and approved as a new provider under the Medicare program, and the Provider was required to submit all of the standard Medicare new provider application forms.[14] Moreover, HCFA issued: (1) a new Health Insurance Benefit Agreement for the SNF and (2) a Provider Tie-In Notice which clearly indicated that HCFA did not consider the establishment of the SNF to involve a CHOW.[15] Accordingly, the record clearly establishes that neither HCFA nor the Intermediary considered the establishment of the SNF to involve a CHOW.

The Provider further argues that HCFA's reliance upon the CHOW argument is also legally impermissible. First, the Provider points out that the Intermediary's position paper cites HCFA Pub. 15-1 § 2533.1 which incorporates provisions relating to change of ownership. However, this manual provision was adopted more than four years after the Provider's SNF commenced operations. Since the provisions

---

[14] See Provider Exhibits P-10, P-11, P-12, P-13 and P-14.

[15] See Provider Exhibits P-15, P-16, P-17, P-18 and P-19.

of HCFA Pub. 15-1 § 2533.1 are not identical to the manual section which it replaced, the Provider contends that the manual revision may not be applied in determining whether the SNF qualifies for a new provider exemption. Second, the Provider maintains that HCFA is attempting to apply the CHOW provisions in one manner for new provider exemption qualification, but in a completely different fashion when it comes to Medicare contracting, surveying, certification, and cost report filing. The Provider insists that it is unlawful and arbitrary and capricious for HCFA to apply the CHOW provisions in an inconsistent and contradictory manner, particularly when the disparate application is obviously intended to serve HCFA's objective of denying new provider status to SNFs such as the Provider in this case.

In determining whether a provider qualifies for a new provider exemption, the key factor in the determination is whether, as an "institution" or a "facility," the provider operated as a skilled nursing facility within the three-year period preceding the commencement of operations. Accordingly, HCFA and the Intermediary are required to examine whether, in a tangible, physical manner, the provider has furnished skilled-nursing services within the previous three years. The Provider contends that HCFA cannot make this showing in the instant case and, thus; has fastened on the pretext that, under Washington CON law, the Provider acquired intangible bed allocation rights from Summit-view. Not being able to make any factual showing that there was a relocation or continuation of Summitview's operations at the Provider's SNF, HCFA seeks to artificially create a relocation or continuation by relying on Washington CON law. The Provider argues that HCFA has used the same approach in other cases involving providers in states which have CON statutes. By relying on state CON statutes to deny new provider exemptions to providers which would otherwise

qualify, HCFA is unfairly and unlawfully penalizing providers who happen to be located in states which have CON statutes. The Provider concludes that HCFA's position results in disparate treatment to these providers and denies them equal protection under the law.

Assuming arguendo that the Provider's SNF is a relocation of Summitview's nursing home, the Provider contends that it is entitled to a new provider exemption under the relocation provisions of HCFA Pub.15-1 § 2604.1.[16] Under § 2604.1, a relocated facility qualifies for a new provider exemption if "a substantially different inpatient population is being served." The Provider asserts that its SNF inpatient population is "substantially different" from the inpatient population at Summitview due to the difference in the level of care provided to patients at its SNF. Specifically, the SNFs patients require, on average, a higher, more intensive level of care than those treated at Summitview based on the fact that a much higher percentage of the Provider's patients are Medicare beneficiaries.[17] This difference in the level of care is also reflected in the higher average lengths of stay and higher nursing hours per patient day at the SNF.[18] Accordingly, even if the establishment of the Provider's SNF represents a "relocation" of Summitview, the SNF qualifies as a new provider under the relocation provisions of HCFA Pub. 15-1 §2604.1.

In summary, the Provider concludes that the applicable law clearly establishes that its SNF qualifies for a new provider

---

[16] See Intermediary Exhibit I-7.

[17] See Provider Exhibit P-21.

[18] See Provider Exhibits P-22 and P-23.

exemption under 42 C.F.R. § 413.30(e), The SNF commenced operations in May of 1993 as a new skilled nursing facility, and not as the relocation or continuation of an existing facility. Moreover, even if the establishment of the SNF is characterized as a relocation, the evidence establishes that the SNF qualifies for a new provider exemption under the relocation provisions of HCFA Pub. 15-1 § 2604.1. Accordingly, the Provider requests that the Board reverse the denial of the exemption, and direct HCFA and the Intermediary to declare that the Provider's SNF qualifies for a new provider exemption.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that HCFA properly adhered to Medicare law, regulations and program instructions, and correctly determined that the Provider does not qualify for a new provider exemption from the RCLs pursuant to the requirements set forth under 42 C.F.R. § 413.30(e). This regulation makes the new provider exemption available to a "provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present or previous ownership, for less than three full years." The Intermediary argues that the phrase ". . . has operated as the type of provider (or the equivalent)" refers to whether or not, prior to certification, the institution engaged in providing skilled nursing care and related services to residents who required medical or nursing care, or rehabilitation services for the rehabilitation of injured and disabled, or sick persons as identified in 42 C.F.R. § 409.33(a) (b) or (c), and did not primarily care and treat residents with mental diseases. The intent of the new provider exemption under 42 C.F.R. § 413.30(e) is to recognize the difficulties in meeting the applicable cost limits during the initial years of developing the ability to provide the kind of

services for which the type of provider is certified. A new provider exemption is not intended to assist an institution in providing "Medicare covered services" or to recover capital expenditures such as the construction of a new building facility.

The Intermediary points out that, although the governing regulation appears simplistic, a number of issues must be analyzed in determining whether to grant an exemption to the statutory cost limits under 42 C.F.R. § 413.30(e). In addition to assuring the timely submission of a written request with supporting documentation, HCFA must determine if any statutory preclusions exist that would disallow an exemption for any given cost reporting year. A review based upon the merits begins with HCFA identifying the "type ofprovider"requesting an exemption. After detehnining the type of provider, the regulation requires that HCFA review the operation of the entire institution under past and present ownership to determine if the institution has operated as the type of provider or its equivalent for less than three full years prior to Medicare certification. Accordingly, HCFA must identify if the institution has undergone a change of ownership prior to its Medicare certification to ensure that the operation of the institution, under past and present ownership, is properly considered when making a determination. HCFA does not limit its review to each "bed" or group of "beds" within an institution when making this determination. HCFA relies on HCFA Pub. 15-1 § 1500 et seq. for the definition of a CHOW, which contains examples of the most common types of transactions that constitute a CHOW for Medicare reimbursement purposes.[19] Although § 1500 et seq. does not include all possible CHOW transactions, additional examples

---

[19] See Intermediary Exhibit I-I0.

were incorporated into HCFA Pub. 15-1 § 2533 et seq. when it was published in 1977 to assist in determining if an institution qualifies for the new provider exemption.[20]

In the instant case, the type of provider requesting the exemption is a SNF. The definition of a SNF is statutory and can be found at 42 U.S.C. § 1395i-3(a)(1). Under the statutory provisions, a SNF provides either skilled nursing and related services or rehabilitative services. In 1987, Congress promulgated the Omnibus Budget Reconciliation Act ("OBRA"), which included the Nursing Home Reform provisions that regulate the certification of long-term care facilities under the Medicare and Medicaid programs. As a result of OBRA, which became effective for services rendered on or after October 1, i990, both Medicare SNFs and Medicaid nursing facilities ("NFs") are required to provide, directly or under arrangement, the same basic range of services described in 42 U.S.C. § 1395i-3(b)(4) and 42 U.S.C. § 1396r (b)(4). This range of services includes those nursing services and specialized rehabilitative services needed to attain or maintain each resident's highest practical level of physical, mental and psychosocial well-being. By applying a uniform set of requirements to all facilities participating in the Medicaid program, Congress eliminated the current regulatory distinctions between skilled and intermediate nursing facilities. Accordingly, if an institution operated as a NF prior to becoming a SNF, it has in fact provided the same basic range of skilled nursing and rehabilitative services.

Consistent with the intent of Congress, OBRA of 1987 established a single standard of skilled care for all Medicare and Medicaid beneficiaries, and forced facilities to provide

---

[20] See Intermediary Exhibit I-6.

skilled care as required by federal law. In support of this interpretation, the Intermediary cites the court decisions in Newman v. Kelly, 849 F. Supp. 228 (1994), where the court found that the term "skilled nursing facility" is the substantial equivalent of the term "nursing facility."[21] In that decision, the court held that:

> Effective October 1, 1990, pursuant to the Nursing Home Reform Law, every nursing home resident covered by Medicare and/or Medicaid is entitled to "skilled nursing care," defined by the statute as the level of care necessary to "attain the highest practicable physical, mental and psycho-social well being of each resident." . . . Viewed in isolation, the difference in the terms "skilled nursing facility" under Medicare and simply "nursing facility" under Medicaid imply that a level of care distinction may be inferred between the two statutes. However, while a technical difference does exist in the terms used to describe the facilities eligible for reimbursement under the two schemes, the substantive definition of the facilities covered is the same in both statutes. The statutory definitions clearly state that "skilled" care must be provided to all residents who require nursing care under either Medicare or Medicaid reimbursement schemes. In addition, there is no indication in these definitions or statutory schemes that any distinction should be made on the basis of level of skilled care required by the resident who is eligible for Medicare or Medicaid reimbursement. Therefore, the court finds that the term "skilled nursing facility" in

---

[21] See Intermediary Exhibit I-5.

§ 1395i-3 is the substantial equivalent of the term "nursing facility."

The Intermediary points out that an institution may have restrictions on the types of services it makes available and the types of health conditions it accepts, or may establish other criteria relating to the admission of patients. In addition, a nursing facility might not have furnished skilled nursing or rehabilitative services as frequently as a skilled nursing facility providing those services on a continuous basis. However, the regulation at 42 C.F.R. § 413.30(e) makes no allowance for institutions providing a low volume of skilled nursing services prior to certification as a SNF. An institution having provided skilled nursing or rehabilitative services for three or more years prior to certification under past and present ownership, regardless of the specific volume, is not entitled to the new provider exemption. The Intermediary notes that this position was affirmed by the Board in the case of Mercy St. Teresa Center v. Blue Cross and Blue Shield Association/AdminaStar Federal, PRRB Dec. No. 98-D64, June 16, 1998, HCFA Admin. Decl. Rev., Medicare and Medicaid Guide (CCH) ¶ 80,006,[22] which was upheld by the United States District Court for the Southern District of Ohio, Western Division, Mercy St. Teresa Center v. Department of Health & Human Services, No. C-1-98-547 (D.S.D. Oh., June 16, 1999).[23] In reviewing the types of services that an institution has provided under past and present ownership, HCFA does not consider how an institution was licensed or certified prior to its participation in the Medicare program to determine the types of services that it has or has not provided.

---

[22] See Intermediary Exhibit I-32.

[23] See Intermediary Exhibit 1-57.

However, licensure and certification status does assist HCFA in determining if the institution could be equivalent to a skilled nursing facility. A SNF may be a nursing home, a distinct part of a hospital, personal care home, assisted living facility, board and care home, domiciliary care facility, rest home, or even a continuing care retirement community. An equivalent institution would be one that has provided the types of services that the "type of provider" is expected to provide under the Medicare program, in accordance with its statutory definition.

The Intermediary points out that the manual provisions at HCFA Pub.15-1 § 2604.1[24] further articulate HCFA's intent to allow for a new provider exemption where an institution underwent a change in location, even if it has operated in the manner of the "type of provider" for which it had been certified or its equivalent (i.e. an exception to the general rule). To qualify under this alternative rule, the institution must demonstrate that: (1) the normal inpatient population can no longer be expected to be served at the new location; and (2) the total number of inpatient days at the new location were substantially less than at the old location for a comparable period during the year prior to the relocation. Both criteria must be met by an institution that has undergone a change in location to be granted new provider status. With regard to the first criterion, HCFA analyzes the "catchment area" or what is commonly referred to as the "health service area" of the institution in its old location and compares that to its new location. In making this analysis, HCFA relies on the State in

---

[24] See Intermediary Exhibit I-7. Note: This manual provision was replaced with HCFA Pub. 15-1 § 2533 in September of 1997 which was designed specifically to address the new Provider exemption as it applies to SNFs. (See Intermediary Exhibits I-6 and I-8).

which the institution is located to determine the health service area of the institution through its State Health Planning mechanism, or its equivalent. As to the second criterion, the total number of inpatient days in the new location for its first three months of operation are compared to the same three months, typically in the year prior to the change in location, at the old location. If neither a substantial change in the population served or a substantial decrease in the number of inpatient days are found, HCFA does not allow for an exemption under this alternative rule.

The institutional complex at issue in the instant case is a non-profit acute care hospital that is located in the Yakima County long-term care planning area, as designated by the State of Washington's DOH. In order to establish its nursing facility, the Provider was required under WAC 246-310-020 to obtain a CON which has been a State of Washington requirement for nursing homes since 1978. The Intermediary notes that four out of five States in the nation have a CON program, a moratorium, or both. Pursuant to these programs, both potential and existing owners of health care facilities are required to live within the constraints of their State CON programs which are specifically designed to limit the growth of new health care facilities. The Provider filed its CON application with DOH on April 17,1991, which was amended on September 29, 1991, stating its intention to obtain the rights to nursing home beds from Summitview, an existing nursing home also located in Yakima County. [25] On March 20, 1992, the State of Washington's DOH approved the application and transferred ownership of the rights to operate nursing home beds from Summitview to the Provider through

[25] See Provider Exhibits P-6 and P-7.

the issuance of CON # 1065. [26] The State of Washington's findings on CON #1065 confirmed this transaction by specifically stating that: "The Sisters of Providence in Washington d/b/a St. Elizabeth Medical Center (St. Elizabeth), Yakima, proposes to obtain the rights to nursing home beds from Summitview Manor, Yakima, and establish a twelve bed skilled nursing home unit at the hospital." The Intermediary further notes that an "Asset Transfer Agreement" between the parties was entered into on July 31, 1990, wherein the Provider purchased the rights to operate 40 nursing home beds. [27] The Provider began operation of a nursing home on May 6, 1993, and was certified for participation in the Medicare program as a SNF and in the Medicaid program as a NF on May 13, 1993.[28]

The Intermediary argues that the purchase and relocation of the operating rights for 12 nursing home beds, pursuant to the Asset Transfer Agreement entered into by the Provider and Summitview, constitute a CHOW as described in HCFA Pub. 15-1 § 1500.7, and further articulated under § 2533.1. Accordingly, the regulatory requirement to review the operation under past and present ownership was triggered, and HCFA found that the institution had been in operation since as early as 1974 under past and present ownership. Although the State of Washington transferred ownership of the right to operate nursing home beds to the Provider on March 20, 1992, HCFA found that Summitview was and is an on-going institution. In other words, only a portion of an existing institution closed and was sold to a new owner. While

---

[26] See Intermediary Exhibits I-11, I-12 and I-13.

[27] See Provider Exhibit P-8.

[28] See Intermediary Exhibit I-40.

the Provider did not begin operation of the nursing home on its campus until May 6, 1993, the period in-between the date of closure and the date of reopening was less than three full years. Even if one were to argue that the CHOW occurred on July 31, 1990, the date of the Asset Transfer Agreement, the Provider's nursing home would have had to be closed through July 31, 1993 to meet the requirements of the break in service policy.

In order to determine if the nursing home had operated in the manner of a SNF or its equivalent under past and present ownership, HCFA compared the supporting documentation submitted by the Provider in its exemption request with the examples of skilled nursing and rehabilitative services set forth under 42 C.F.R. 9 409.33 (a), (b) and (c). The Provider indicated in its application that the nursing home, under past or present ownership, first performed skilled nursing or rehabilitation services on May 6, 1993. To validate this documentation, HCFA utilized data found in the On-Line Survey and Certification and Reporting System ("OSCAR"), which is a HCFA database used for survey and certification activities. Based on this comparative analysis, HCFA found that the Provider's documentation was not accurate, and that the nursing home, under prior ownership, had provided skilled nursing or rehabilitative services for more than three years since it began operating as early as 1974.

The Intermediary advises that Summit-view participated as a nursing facility from February 1, 1974 through December 31, 1991, and has participated as a dually certified (Medicare and Medicaid) long term care facility since January 1, 1992. Accordingly, HCFA was able to extract data from the Residents Census and Characteristics Reports submitted by

Summitview during various annual surveys,[29] which revealed that Summitview had provided both skilled nursing and rehabilitative services for more than three years prior to the purchase and relocation of a portion of the institution by the Provider. To be eligible for an exemption under the regulatory and manual provisions, an institution must demonstrate a complete change in the operation of the institution (e.g., from solely custodial care to the provision of skilled nursing and related services or rehabilitative services). The Intermediary insists that changes of an institution's ownership or geographic location do not in itself alter the type of health care furnished, and are not to be considered in the determination of the length of operation.

While the Provider has taken the position that the nursing facility operated by Summit-view provided solely custodial services, HCFA's factual determinations revealed that skilled nursing and rehabilitative services were performed under prior ownership. Moreover, even Summitview's Medicaid status as a NF required it to provide NF services. The regulations at 42 C.F.R. 9 440.40 define NF services as those needed on a daily basis and required to be furnished on an inpatient basis pursuant to 42 C.F.R. 99 409.31 through 409.35. These regulations govern Medicare coverage of services provided in a SNF, and are used by HCFA when determining whether an institution has operated in the manner of a SNF prior to certification in the Medicare program. Custodial care, on the other hand, is essentially personal care that does not require the attention of trained medical or paramedical personnel. Based on the proper analysis of the facts presented, the Intermediary contends that HCFA properly concluded that the Provider does not qualify for a

---

[29] See Intermediary Exhibits I-20, I-21 and I-22.

new provider exemption under 42 C.F.R. 9 413.30(e). With respect to the change in location exemption under HCFA Pub. 15-1 § 2604.1, HCFA denied this exemption alternative because the Provider chose not to submit the required documentation for making this evaluation. However, in its determination letter, HCFA left open the opportunity for a review under the change in location provision should the Provider submit the documentation requested.

In consideration of the facts in this case, the Intermediary believes the Board must find that HCFA properly adhered to Medicare law, regulations and program instructions by affirming HCFA's denial of the Provider's exemption request. This would be consistent with other determinations by HCFA that have been upheld by the Board in numerous prior decisions.[30]

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. LAW - 42 U.S.C.:

§ 1395i-3 et seq. Requirements For, Assuring Quality Of Care In, Skilled Nursing Facilities

§ 1396r(b)(4) Requirements for Nursing Facilities Provision of Services and Activities

Regulations - 42 C.F.R.:

§§ 405.1835-.1841 Board Jurisdiction

---

[30] See Intermediary Exhibits I-24, I-25, I-26, I-55 and I-56.

§ 409.31	Level of Care Requirement
§ 409.33 et seq	Examples of Skilled Nursing and Rehabilitation Services
§ 409.35	Criteria for Practical Matter
§ 413.30(e)	Limitations on Reimbursable Cost-Exemptions
§ 413.30(f)	Limitations on Reimbursable Cost-Exemptions
§ 440.40	Nursing Facility Services

3. Program Instructions - Provider Reimbursement Manual - Part I (HCFA Pub. 15-1):

§ 1500 et seq.	Change of Ownership
§ 1500.7	Other Disposition of Assets
§ 2533 et seq.	Request for Exemption from SNF Cost Limits
§ 2533.1	Requests Regarding New Provider Exemption
§ 2604.1	Definitions - New Provider

4. Case Law:

Newman v. Kelly, 849 F. Supp. 228 (1994).

Mercy St. Teresa Center v. Department of Health & Human Services, No. C-1-98-547, (D.S.D. Oh., June 16, 1999).

Mercy St. Teresa Center v. Blue Cross and Blue Shield Association/AdminaStar Federal, PRRB Dec. No. 98-D64, June 16, 1998, HCFA Admin. Decl. Rev., Medicare and Medicaid Guide (CCH) ¶ 80,006.

5. Other:

Omnibus Budget Reconciliation Act of 1987 - (OBRA - 1987).

Revised Code of Washington ("RCW")

RCW 70.38.105 et seq.	Health Services and Facilities Requiring Certificate of Need Fees

Washington Administrative Code ("WAC"):

WAC 246-310-020	Certificate of Need-Applicability
WAC 246-310-350	Nursing Home and Continuing Care Retirement Community Definitions
WAC 246-310-390	Nursing Home Bed Need Adjustments

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and post-hearing briefs, finds and concludes that HCFA properly denied the Provider's request for a new provider exemption from the RCLs under the controlling regulatory provisions of 42 C.F.R. § 413.30(e).

The Board finds that the evidence in the record clearly demonstrates that the 12 beds obtained by the Provider for the establishment of its hospital-based SNF were pre-existing beds that were purchased from Summitview pursuant to the "Asset Transfer Agreement" entered into by the parties on July 31, 1990.[31] This agreement sets forth Summitview's intent to reduce its licensed bed capacity by selling its right, title and interest to the intangible right to use 40 nursing home beds which were being used at its facility. The Provider agreed to pay Summit-view a total purchase price of $172,000 ($4,300 per bed) and to promptly file an application for a CON with the State of Washington's DOH for the relocation of the beds to its hospital facility. On April 17, 1991, the Provider filed its CON application with DOH,[32] and DOH approved the application on March 20, 1992, which transferred ownership of the rights to operate nursing home beds from Summitview to the Provider.[33] Accordingly, the Board concludes that the documentation clearly establishes that the Provider purchased and relocated the operating rights to 12 existing and

---

[31] See Provider Exhibit P-8.

[32] See Provider Exhibits P-6 and P-7.

[33] See Provider Exhibits I- 11, I- 12 and I- 13.

operational beds from Summitview, and that the transaction was effected by means of a CHOW as set forth under HCFA Pub. 15-1 § 1500.7 and further clarified by the provisions in HCFA Pub. 15-1 § 2533.1.

The record shows that the Provider constructed a new 12-bed SNF which began operation on May 6, 1993, and became certified for participation in the Medicare program as a SNF on May 13, 1993.[34] On June 12, 1996, the Provider filed its request for an exemption to the Medicare RCLs as a new provider under the regulatory provisions of 42 C.F.R. § 413.30(e). This controlling regulatory provision states in part:

> Exemptions from the limits imposed under this section may be granted to a new provider. A new provider is a provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years.

42 C.F.R. §413.30(e)

The Board finds that the above stated Medicare regulation, and the clarifying manual provisions at HCFA Pub. 15-1 § 2533.1 and § 2604.1, are the governing Medicare rules which must be applied in determining whether the Provider qualifies for an exemption from the RCLs as a new provider. Accordingly, the fundamental issue to be resolved in this case is whether the Provider's SNF, under past or present ownership, furnished skilled nursing or rehabilitative services for less than three full years. Inasmuch as the Provider's SNF

---

[34] See Intermediary Exhibit I-40.

was established as a result of a CHOW and relocation of beds from Summitview, a review of Summitview's previous operation is both proper and necessary in determining whether the Provider meets the new provider requirements set forth in the regulatory and manual provisions.

The evidence shows that during the three-year look back period, Summitview had been "operated as" a SNF since some skilled nursing services had been provided to its patients. From February 1, 1974 through December 31, 1991, Summitview participated in the Medicaid program as a nursing facility, and to date has participated as a dually certified (Medicare and Medicaid) long term care facility since January 1, 1992. Through the use of the Residents Census and Characteristic Reports submitted by Summitview,[35] HCFA was able to extract data which indicated that Summitview did perform some level of skilled nursing services within the three-year look back period prior to the Provider's purchase and relocation of a portion of the institution to its hospital facility. Whereas the Provider indicated in its new provider exemption request that skilled nursing or rehabilitative services were first performed on May 6, 1993, the Board notes that HCFA found that this statement was not accurate. Utilizing data found in the OSCAR report, HCFA determined that, under prior ownership, the nursing h[illegible]e had provided skilled nursing and related services or rehabilitative services on various survey dates starting in 1988 and ending in 1991.[36] Based on the evidence presented, it is the Board's conclusion that skilled nursing services were

---

[35] See Intermediary Exhibits I-20, I-21 and I-22.

[36] See Intermediary Exhibit I-17 and Tr. Vol. 2 at 30-32.

rendered at the nursing facility during the three-year look back period.

The Board notes that the focus of the Provider's primary position is that the term "new provider" relates to the operations of the provider as a physical institution or facility, and that its SNF did not operate as a "facility" or an "institution" within the three-year period preceding the commencement of operations. The Board rejects the Provider's constricted interpretation, and finds that the proper application of the regulatory and manual provisions mandates an examination of the previous owner's operation to determine if the Provider meets the requirement of having not operated for more than three full years as the type of provider for which it is certified. Accordingly, the Board concurs with HCFA's determination that the operation of Summitview must also be considered since it was the pre-existing facility from which the CON rights for the 12 existing beds were obtained. With respect to the Provider's contention that it qualifies for a new provider exemption under the relocation provisions of HCFA Pub. 15-1 § 2604.1, the Board finds that the Provider has furnished no documentation which would permit such a determination.

In summary, the Board concludes that HCFA properly applied the applicable Medicare policy, and that the Provider is not entitled to an exemption as a new provider under 42 C.F.R. § 413.30(e). However, the Board notes that the Provider sought and obtained an exception to the RCLs under 42 C.F.R. § 413.30 (f) for the FYEs December 31, 1993, 1994 and 1995.

DECISION AND ORDER:

HCFA properly denied the Provider's request that its skilled nursing unit receive an exemption from the RCLs as a new provider Under 42 C.F.R. § 413.30(e). HCFA's determination is affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover; Jr., Esquire
Charles R. Barker
Stanley J. Sokolove

FOR THE BOARD

MAY 16 2001

/s/
Irvin W. Kues
Chairman

Supreme Court, U.S.
FILED
AUG 2 - 2004
OFFICE OF THE CLERK

(2)

No. 03-1609

In the Supreme Court of the United States

PROVIDENCE HEALTH SYSTEM-WASHINGTON, DBA PROVIDENCE YAKIMA MEDICAL CENTER, DBA PROVIDENCE YAKIMA MEDICAL CENTER SKILLED NURSING FACILITY, PETITIONER

v.

TOMMY G. THOMPSON, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

PAUL D. CLEMENT
Acting Solicitor General
Counsel of Record

PETER D. KEISLER
Assistant Attorney General

BARBARA C. BIDDLE
ANTHONY A. YANG
ANNE MURPHY
Attorneys
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

QUESTION PRESENTED

The Secretary of Health and Human Services has issued a Medicare regulation, 42 C.F.R. 413.30(e) (1995), that was in effect only for cost reporting periods beginning before July 1, 1998. The question presented is whether the Secretary permissibly interpreted that regulation to determine that petitioner was not a "new provider" based on its acquisition of rights to operate skilled nursing beds from a previously-existing facility.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statement	2
Argument	5
Conclusion	9

TABLE OF AUTHORITIES

Cases:

Ashtabula County Med. Ctr. v. *Thompson*, 352 F.3d 1090 (6th Cir. 2003)	6
Barnhart v. *Walton*, 535 U.S. 212 (2002)	8
Christensen v. *Harris County*, 529 U.S. 576 (2000)	7
Davis v. *United States*, 495 U.S. 472 (1990)	7
Maryland Gen. Hosp., Inc. v. *Thompson*, 308 F.3d 340 (4th Cir. 2002)	6
Paragon Health Network, Inc. v. *Thompson*, 251 F.3d 1141 (7th Cir. 2001)	5, 6
SEC v. *Zandford*, 535 U.S. 813 (2002)	8
South Shore Hosp., Inc. v. *Thompson*, 308 F.3d 91 (1st Cir. 2002)	6
Thomas Jefferson Univ. v. *Shalala*, 512 U.S. 504 (1994)	5, 7
United States v. *Mead Corp.*, 533 U.S. 218 (2001)	7, 8
Washington State Dep't of Soc. & Health Servs. v. *Guardianship Estate of Keffeler*, 527 U.S. 371 (2003)	8

Statutes:

Medicare Act, Tit. XVIII, 42 U.S.C. 1395 *et seq.*:	
42 U.S.C. 1395x(v)(7)(D)	2

Statutes and regulations—Continued: Page

42 U.S.C. 1395*oo* 9
42 U.S.C. 1395yy 5
42 U.S.C. 1395yy(a) 2
42 U.S.C. 1395yy(c) 2, 7
42 U.S.C. 1395yy(e)(1) 2, 7
42 U.S.C. 1395yy(e)(2)(D) 2, 7
42 U.S.C. 1395yy(e)(2)(E) 2, 7

42 C.F.R.:

Section 413.1(g)(2)(i) 2, 7
Section 413.30(e) (1995) 2, 3, 5, 6

Miscellaneous:

44 Fed. Reg. 31,802 (1979) 2, 5

In the Supreme Court of the United States

No. 03-1609

PROVIDENCE HEALTH SYSTEM-WASHINGTON, DBA PROVIDENCE YAKIMA MEDICAL CENTER, DBA PROVIDENCE YAKIMA MEDICAL CENTER SKILLED NURSING FACILITY, PETITIONER

v.

TOMMY G. THOMPSON, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 5a-17a) is reported at 353 F.3d 661. The opinion of the district court (Pet. App. 18a-32a) is unreported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 3a-4a) was entered on December 17, 2003. The petition for rehearing was denied on March 1, 2004 (Pet. App. 1a-2a). The petition for a writ of certiorari was filed on May 28,

2004. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

This action involves the Secretary's interpretation of his regulation providing for a "new provider" exemption from Medicare's routine service cost limits. The regulation was an aspect of the "reasonable cost" system of Medicare reimbursement and it no longer applies under the "prospective payment system" that has been in effect for skilled nursing facilities for cost reporting periods beginning on or after July 1, 1998. 42 U.S.C. 1395yy(e)(1), (2)(D) and (E); 42 C.F.R. 413.1(g)(2)(i).

1. Under the "reasonable cost" system of reimbursement under the Medicare Act, Congress limited the amount that skilled nursing facilities could receive in reimbursement for non-capital routine service costs. 42 U.S.C. 1395x(v)(7)(D), 1395yy(a). The Act specifies that the Secretary of Health and Human Services (HHS) "may make adjustment in the limits * * * to the extent the Secretary deems appropriate, based upon case mix or circumstances beyond the control of the facility." 42 U.S.C. 1395yy(c). In 1979, the Secretary promulgated a regulation, 42 C.F.R. 413.30(e), that exempted a "new provider" from the routine cost limits otherwise applicable to skilled nursing facilities. The regulation was designed to address the "problem[] of initial underutilization" sometimes faced by new inpatient skilled nursing facilities. 44 Fed. Reg. 31,802 (1979). The regulation defines the term "new provider" as a "provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and *previous ownership*, for less than three full years." 42 C.F.R. 413.30(e)(1995) (emphasis added). The regulation does not define the phrase "previous ownership."

2. Petitioner is a Medicare-certified skilled nursing facility located in the city and county of Yakima, Washington. The State requires any new health care entity to obtain a "Certificate of Need." Pet. App. 6a-7a. The State, in some areas, has imposed a moratorium on the addition of new nursing facility beds, but the State permits entities in moratorium areas to purchase the rights to operate existing beds from other facilities.

In 1990, petitioner purchased the rights to operate twelve nursing facility beds from an existing nursing facility, Summitview, which allowed petitioner to obtain a certificate of need from the State of Washington. Petitioner thereafter requested a "new provider" exemption under 42 C.F.R. 413.30(e). The request was denied by the fiscal intermediary responsible for the initial processing of Medicare reimbursement claims. The Provider Reimbursement Review Board (Board) within HHS affirmed, holding that petitioner did not qualify as a new provider under the regulation. Pet. App. 33a-65a. The Board adopted the intermediary's conclusion that the regulation requires a "review the operation of the entire institution under past and present ownership to determine if the institution has operated as the type of provider or its equivalent for less than three full years," and that it was appropriate to determine "if the institution has undergone a change of ownership * * * to ensure that the operation of the institution, under past and present ownership, is properly considered." *Id.* at 49a. The Board also found that the petitioner's facility had undergone a change of ownership by virtue of its purchase of operating bed rights from Summitview and accordingly that Summitview's operating history was properly considered in determining that petitioner was not a new provider. *Id.* at 61a-64a.

3. The district court reversed, Pet. App. 18a-32a, holding that the Board's decision "was contrary to the plain meaning of the regulation," *id.* at 26a.

4. The court of appeals reversed and remanded for the entry of judgment in favor of the Secretary. Pet. App. 1a-17a. The court of appeals observed that "[t]he critical question here is whether that characteristic of [petitioner's] operations that makes it a provider—the provision of inpatient services—can be said to have been previously owned by Summitview." *Id.* at 10a. The court held that "the plain language of 42 C.F.R. § 413.30(e) does not clearly address whether Summitview's ownership of the bed rights it transferred to [petitioner] constitutes previous ownership." Pet. App. 10a. The court also concluded the Secretary permissibly "chose to narrow its determination of [petitioner's] previous ownership to the question of whether the bed rights were previously owned by another [skilled nursing facility]," because "bed rights are an essential characteristic of providership." *Id.* at 12a.

The court of appeals also found that the Secretary's construction of 42 C.F.R. 413.30(e) (1995) "reasonably conforms to the * * * purpose" of the regulation. Pet. App. 16a. The court explained that in States like Washington, where there is a "de facto moratorium" on certain healthcare facilities, the Secretary "reasonably decided that no additional benefit is gained in the overall delivery of health care services when beds are merely shifted from one provider to another." *Id.* at 15a. The court similarly reasoned that because "providers in moratorium states will tend to suffer less from the effects of competition and any initial under-utilization, the Secretary has reasonably determined that they have less of a need for the exemption." *Ibid.*

ARGUMENT

1. a. The court of appeals correctly held that the Secretary permissibly construed his regulation, 42 C.F.R. 413.30(e) (1995), to exclude providers such as petitioner who are licensed by the State as skilled nursing facilities only by virtue of the purchase of the right to operating beds from a pre-existing facility. The regulation provides that a new provider is one that has operated for less than three full years under both present and "previous ownership," but the regulation does not specify the circumstances in which a provider may have undergone a change of ownership based on the purchase of any particular type or number of assets from another facility. Pet. App. 11a ("[T]he interplay of 'provider' and 'previous ownership' renders the regulation inherently ambiguous as to the critical question at issue in this case."); accord *South Shore Hosp., Inc.* v. *Thompson*, 308 F.3d 91, 98 (1st Cir. 2002); *Paragon Health Network* v. *Thompson*, 251 F.3d 1141, 1148 (7th Cir. 2001). The Secretary accordingly had the latitude to focus on the purchase of operating rights from a pre-existing facility when those rights were an essential feature of the provider's existence and right to operate under state law. See generally *Thomas Jefferson Univ.* v. *Shalala*, 512 U.S. 504, 512 (1994) (Secretary's interpretation of his Medicare regulations is entitled to "substantial deference.").

Moreover, sound reasons justify the Secretary's interpretation. The new provider exemption was not intended to reimburse a provider for the start-up capital costs of building a new facility. Pet. App. 49a. Indeed, the exemption related to routine *operating* costs, not capital costs, 42 U.S.C. 13955yy, and was designed to guard against the risk of underutilization by newly constituted facilities, 44 Fed. Reg. 31,802 (1979). Accordingly, the

Secretary reasonably determined that in moratorium States that place caps on the number of operating beds that may exist in a geographic area, a provider who has purchased the right to operate beds from a pre-existing facility in the same geographic area is not likely to face underutilization by patients. *South Shore Hosp.*, 308 F.3d at 101; *Paragon Health Network*, 251 F.3d at 1149; see *Maryland Gen. Hosp.* v. *Thompson*, 308 F.3d 340, 347 (4th Cir. 2002) (observing that the Secretary's interpretation of the regulation "may well be reasonable when considered against the realities of the skilled nursing industry," and that "the Secretary might reasonably believe that the new provider exemption should be applicable only when a new facility increases the options available to the community it serves by increasing the number of beds actually in use in that community.").

b. Petitioner argues that this Court's review is warranted to resolve a conflict in the circuits whether the Secretary's construction of 42 C.F.R. 413.30(e) (1995) conflicts with the text of the regulation. Pet. 4-13. In contrast to the decision below, which joined in the conclusion of the First Circuit in *South Shore Hosp.*, *supra*, and the Seventh Circuit's decision in *Paragon Health Network*, *supra*, the Fourth and Sixth Circuits have found that the regulation is plain in including facilities such as petitioner's. *Ashtabula County Med. Ctr.* v. *Thompson*, 352 F.3d 1090, 1097 (6th Cir. 2003); *Maryland Gen. Hosp.* v. *Thompson*, 308 F.3d at 346. That conflict, however, does not warrant this Court's review because the regulation at issue only applies to skilled nursing facilities seeking reimbursement for routine operating costs for cost reports for reporting periods beginning before July 1, 1998. For cost reporting periods beginning on or after July 1, 1998, such facilities are reimbursed pursuant to Medicare's

prospective payment system, under which the Secretary's new provider regulation has no application. 42 U.S.C. 1395yy(e)(1), (2)(D) and (E); 42 C.F.R. 413.1(g)(2)(i). Nor is the fiscal impact of the question presented so substantial as to justify intervention by this Court despite the change in the law that went into effect more than six years ago. To the contrary, the Secretary informs us that the total amount in controversy for the nine "new provider" exemption cases involving the purchase of bed rights, including the decision below, that are pending either before HHS or the courts is less than $15 million.

2. Petitioner also argues (Pet. 13-19) that this Court's review is warranted to determine whether an agency's interpretation of its own regulation warrants substantial deference in light of the Court's decision in *United States* v. *Mead Corp.*, 533 U.S. 218 (2001), and *Christensen* v. *Harris County*, 529 U.S. 576 (2000). Petitioner did not advance that contention in the court of appeals, however, and this Court should decline to consider the issue in the first instance. *E.g.*, *Davis* v. *United States*, 495 U.S. 472, 489 (1990) ("Because this argument was neither raised before nor decided by the Court of Appeals, we decline to address it here.").

In any event, *Mead* and *Christensen* provide no basis for reconsideration of the settled principle that an agency's interpretation of its own regulation should be given "controlling weight unless it is plainly erroneous or inconsistent with the regulation," *Thomas Jefferson Univ.*, 512 U.S. at 512, and petitioner cites to no decision (nor are we aware of any) holding to the contrary. *Mead* and *Christensen* concerned the level of deference due to agency interpretations of statutes where the agency had not promulgated a relevant regulation. *Mead Corp.*, 533 U.S. at 227-238; *Christensen*, 529 U.S. at 587. And since those

decisions were rendered, the Court has reiterated that deference is owed to an agency's construction of its regulations. *Washington State Dep't of Soc. & Health Servs.* v. *Guardian Estate of Keffeler*, 537 U.S. 371, 387-388 (2003) ("[T]he Commissioner's interpretation of her own regulations is eminently sensible and should have been given deference."); *Barnhart* v. *Walton*, 535 U.S. 212, 217 (2002) ("Courts grant an agency's interpretation of its own regulations considerable legal leeway.").

Moreover, *Mead* explicitly recognized that deference is due when Congress would have so intended. 533 U.S. at 229-230. Under the Medicare program, Congress specifically granted the Secretary substantive rule-making authority to grant a routine costs exemption as the Secretary "deems appropriate," 42 U.S.C. 1395yy(c), and provided for formal administrative adjudication to resolve reimbursement claims under the Act and implementing regulations. 42 U.S.C. 1395oo. Interpretation of statutes in such adjudications are entitled to deference. *SEC* v. *Zandford*, 535 U.S. 813, 819-820 (2002). A fortiori, deference is owed to an agency's interpretation of its own regulations in such adjudications. In this case, the Secretary's interpretation of his regulations was articulated both in interpretive guidance and in the decision of the Provider Reimbursement Board in its adjudication of petitioner's claim. Pet. App. 8a, 12a-14a, 61a-65a. The court of appeals accordingly correctly deferred to the Secretary's construction of the regulation.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

PAUL D. CLEMENT
Acting Solicitor General

PETER D. KEISLER
Assistant Attorney General

BARBARA C. BIDDLE
ANTHONY A. YANG
ANNE MURPHY
Attorneys

AUGUST 2004